INFLUENZA MAY NOT BE PREVENTED BY CURRENT VACCINE
(From MMWR, January 29, 1988)

Laboratory studies, as well as preliminary observations during outbreaks of influenza A (H3N2) among high-risk residents of nursing homes, suggest that the A/Leningrad/360/86 component of the current vaccine may not provide optimal protection against presently circulating strains. These findings emphasize the need for health care providers to be aware of the recommendations for use of the antiviral drug amantadine for controlling outbreaks and for prophylaxis or treatment of unprotected patients. Because amantadine, which is a prescription drug, must be given before exposure to prevent infection or within the first 1 or 2 days after onset of illness for treatment, contingency plans for its rapid use are needed. These plans include obtaining a physician's order to give the drug to high-risk patients at the first signs of influenza illness, knowing the precautions concerning dosage of the drug (particularly for persons with known renal insufficiency or with presumed reduced renal function, such as those over 64 years of age), and arranging for an adequate supply of the drug.

A fact sheet on amantadine, directed particularly at use in institutions caring for high-risk persons, is available through the Office of Public Inquiries, Centers for Disease Control, 1600 Clifton Road, NE, Atlanta, GA 30333.

CHANGES IN ADMINISTRATIVE RULES OF MONTANA (Continued)

As of November 27, 1988 many of the Administrative Rules of Montana concerning communicable disease control were changed. This is a continuation of a section-by-section review of those changes.

Newborn Eye Treatment

In the former format, the discussion concerning this was located in the section on specific control measures for certain communicable diseases. It was not easily located when someone wished to refer to the requirements for newborn eye treatment. Therefore, the section was moved to the Maternal and Child Health Administrative Rules of Montana, Chapter 24, but is still referenced in Chapter 28, Communicable Disease Control of Title 50.

Some changes were made in the rule and it is printed in full below:

> Newborn Eye Treatment (1) A physician, nurse-midwife, or any other person who assists at the birth of any infant must, within the time limit stated in (3) below, instill or have instilled into each conjunctival sac of the newborn one of the following:
> (a) erythromycin (0.5%) ophthalmic ointment or drops from single-use tubes or ampules;
> (b) tetracycline (1%) ophthalmic ointment or drops from single-use tubes or ampules; or
> (c) silver nitrate solution (1%) in single-dose ampules.
> (2) A prophylactic agent referred to in (1) above may not be flushed from a newborn's eyes after instillation.
> (3) The prophylactic agent must be administered to a newborn within one hour after its birth unless it is physically impossible to obtain an agent within that time, in which case the agent must be administered as soon as possible.

Report Contents

A report of a case must include the following information: name, age, dates of onset of disease, date disease reported, name and address of case's physician, whether case is suspected or confirmed and the name of the reporter or other person the Department can contact for further information regarding the case. There is one deviation from this and it is related to a report of "potential AIDS" or Human Immunodeficiency Virus antibody testing. A report of "potential AIDS" must include the following: date of test, name and address of reporter and initials of the person tested or any other identifier, such as a number, assigned by the reporter which does not reveal the name of the person tested. HIV positivity is also exempted from the rule allowing the Department to request more information related to case management about a reported case.

Although confidentiality is addressed by an entire statute, Montana Code Annotated Title 50-16-501-553, the Uniform Health Care Information Act, confidentiality related to reporting of AIDS and "potential AIDS" is addressed in the communicable disease rules. The rules specifically state, "The name of any case of AIDS or potential AIDS and the name and address of the reporter of any such case are confidential and not open to public inspection."

VHS TAPE AVAILABLE FOR LOAN

A tape entitled, "Prevent the Spread of Infection in Your Child Care Center" is available for loan free of charge from the Montana Immunization Program. Please write the Program at the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620, or phone Dona McClung at 444-3986. Specify the date(s) you wish to reserve the tape for your use.

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Volume: 12:1 **Month of:** JANUARY - 1988

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JANUARY 1988	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmoneliosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn											2	1		1	
Blaine				2								3			
Broadwater															
Carbon												1			
Carter															
Cascade			1	5											
Chouteau															
Custer															
Daniels															
Dawson															
Deer Lodge															
Fallon															
Fergus			1									1			
Flathead			1			1	1						1		
Gallatin				2										2	
Garfield												1			
Glacier				6							10	1			
Golden Valley															
Granite															
Hill				1								1			
Jefferson															
Judith Basin												1			
Lake															
Lewis & Clark				2			1								
Liberty															
Lincoln															
McCone												1			
Madison						1									
Meagher															
Mineral															
Missoula	1			3		1	2						1		
Musselshell												1			
Park															
Petroleum															
Phillips															
Pondera						1			2						
Powder River															
Powell															
Prairie															
Ravalli													1	1	
Richland															
Roosevelt				4								1			
Rosebud						1								7	
Sanders	1														
Sheridan															
Silver Bow															
Stillwater															
Sweet Grass															
Teton												2			
Toole															
Treasure												1			
Valley															
Wheatland															
Wibaux															
Yellowstone			1	7	1		2	1				1		1	
MONTHLY TOTAL 1988	2	*224*	4	32	1	5	6	1	2	0	12	17	3	12	0
MONTHLY TOTAL 1987	1	125	4	57	3	6	2	1	0	0	7	6	2	2	0
MONTHLY TOTAL 1986	8	22	11	61	2	10	2	0	0	1	16	27	7	3	1
TOTAL TO DATE 1988	2	224	4	32	1	5	6	1	2	0	12	17	3	12	0
TOTAL TO DATE 1987	1	125	4	57	3	6	2	1	0	0	7	6	2	2	0
TOTAL TO DATE 1986	8	22	11	61	2	10	2	0	0	1	16	27	7	3	1

OTHER DISEASES: Chickenpox: Cascade, 60; Fergus, 20; Gallatin, 1; Judith Basin, 1; Lake, 37; Yellowstone, 4; Syphilis: Yellowstone, 1 primary case and 1 early latent case under 1 year; Typhoid Fever: Gallatin, 1

* Breakdown by county not available for month of January. Numbers reflect total cases for the state.

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MONTANA YOUTH 2000 CONFERENCE:

"Developing Strategies for Teens-at-Risk"

May 13 and 14, 1988

Montana State University Campus
Bozeman, Montana

THE CHALLENGE: Our Nation needs the productive energies of all its youth to ensure continued social and economic progress as we move into the 21st century. Yet 10 to 15 percent of our 16-to-19 year olds are at risk of not successfully making the transition into productive and responsible adulthood. The problems facing our youth are alarming, the issues compelling, and fresh solutions are needed.

-- One million students drop out of high school annually. In Montana between 15% and 18% of the students who begin ninth grade next fall will not graduate.

-- More than one million adolescents become pregnant annually. Of the estimated 2,363 teen pregnancies in Montana in 1986, 37% (or 865 pregnancies) were to females 17 years old and younger. Half of these young women will never complete high school.

-- One out of eight 17 year olds in this country is functionally illiterate.

-- Approximately 3 million young people, 21 percent of all 14-to-17 year old, have problems with alcohol. This translates to a conservative estimate of over 10,000 young Montanans in this age group with alcohol problems.

-- Automobile accidents, suicides, and homicides are the three leading causes of death among teenagers in Montana. Many of these deaths are also drug-related.

-- More than one million young people run away from home or are homeless each year.

CALL TO ACTION: On May 13 and 14, 1988, on the Montana State University Campus, Bozeman, a conference will be held to develop solutions to some of the complex problems facing our youth. They are preventable, if we come together and work together as a community taking action!

WHAT THE CONFERENCE WILL COVER:

-- Provide current information on teen social and health problems.

-- Identify core, root causes of high-risk teen behavior.

-- Present primary prevention programs in Montana that are improving youth self-sufficiency and health.

-- Provide opportunity for community teams to strategize local coalition-building and action plans to meet the needs of our youth.

WHO SHOULD ATTEND: Teams of people made up of teens, parents, youth workers, educators, health professionals, or community movers and shakers are encouraged to attend. Group rates will be offered for individuals registering as a team. Individual registrants are also welcome.

REGISTRATION FEES:

Family/Team: Three or more individuals with at least one student in 6th - 12th grade.
Team Adult -- $20.00
Team Youth -- $15.00

Individual Adult -- $25.00

Individual Youth -- $20.00

SPONSORS:

-- Mountain Bell Foundation/A US WEST Company
-- Montana State Family Planning Program
-- Montana State Perinatal Program
-- Healthy Mothers, Healthy Babies' Montana PATH Project (Promoting Action for Teen Health)

FOR MORE INFORMATION ABOUT THE CONFERENCE, CONTACT:

Continuing Education for the
Health Professional
318 Montana Hall
Montana State University
Bozeman, MT 59717-0001
(406) 994-4930

The Montana PATH Project
c/o Healthy Mothers, Healthy Babies
P. O. Box 876
Helena, MT 59624
(406) 449-8611

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FEBRUARY 1988

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead			1												
Big Horn				1								1			
Blaine												1			
Broadwater															
Carbon															
Carter											3	1			
Cascade			1	12		1									
Chouteau															
Custer				1											
Daniels												1			
Dawson															
Deer Lodge															
Fallon															
Fergus			4									3			
Flathead				2	1	6							1		
Gallatin			3												
Garfield															
Glacier				2											
Golden Valley															
Granite															
Hill				1			1								
Jefferson							1								
Judith Basin															
Lake				1											
Lewis & Clark			1	5									1		
Liberty			1										1		
Lincoln															
McCone															
Madison															
Meagher															
Mineral															
Missoula	1			1		1									
Musselshell															
Park															
Petroleum												1			
Phillips															
Pondera												3			
Powder River											1				
Powell	1												1		
Prairie															
Ravalli				1											
Richland					1										
Roosevelt				1								1			
Rosebud															
Sanders			1												
Sheridan															
Silver Bow	1		16				1								
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure												1			
Valley												4			
Wheatland															
Wibaux															
Yellowstone			1	9		1	1						1		
MONTHLY TOTAL 19 88	3	*176	29	37	2	9	4	0	0	0	4	17	5	0	0
MONTHLY TOTAL 19 87	0	88	12	54	2	2	4	1	0	0	3	10	3	4	2
MONTHLY TOTAL 19 86	3	35	5	44	2	4	3	0	0	3	6	15	5	1	1
TOTAL TO DATE 19 88	5	400	33	69	3	14	10	1	2	0	16	34	8	12	0
TOTAL TO DATE 19 87	1	213	16	111	5	8	6	2	0	0	10	16	5	6	2
TOTAL TO DATE 19 86	12	57	16	105	4	14	5	1	3	4	22	42	12	4	2

OTHER DISEASES: Chickenpox: Cascade,16; Custer, 18; Lake, 24; Liberty, 15; Missoula, 7; Silver Bow, 6; Yellowstone, 1; Early Latent Syphilis under 1 year: Flathead, 1; Sanders,1; Hib Invasive Disease: Gallatin, 1; Yellowstone, 2; Listeremia Meningitis: Lewis & Clark,1

*Breakdown by county not available for month of February. Numbers reflect total reported cases for the state.

Changes in Administrative Rules of Montana (continued)

As of November 27, 1987, many of the Administrative Rules of Montana (ARM) concerning communicable disease control were changed. This is a continuation of a section-by-section review of those changes.

General Control Measures

The term "sensitive occupation" is now used to describe persons working in settings in which a communicable disease in the worker could pose more than the usual risk for others. The term includes health care workers, etc. but it is chosen so a particular occupation is not excluded.

The section on funerals is unchanged except reference is made to another chapter containing specific rules regarding dead human bodies. Chapter 29 contains the ARM related to Department of Health and Environmental Sciences' (DHES) ARM entitled Dead Human Bodies. Within this chapter the definition of specified communicable diseases was expanded to include AIDS, hepatitis B, nonA-nonB hepatitis and unspecified hepatitis. Designation of a body as being one of a person dying with a specified communicable disease has the following effects:

(1) the attending physician must notify the local health officer and the DHES of the death.
(2) the local health officer must notify anyone at risk of having the disease transmitted to them via body handling
(3) the body must be embalmed.

Guidelines for transportation and importation of communicable disease cases have been made more specific. Only persons with communicable diseases having ARM required isolation or quarantine need to be considered for regulation of travel. One needs to consult subchapter 6 of Chapter 28 to find whether or not a disease requires isolation or quarantine.

Confirmation of disease is essentially a new section of the ARM. A local health officer must ensure a specimen from persons with the diseases listed below are submitted to DHES. The diseases are as follows:

Amebiasis
Anthrax
Botulism (including infant botulism)
Brucellosis
Chancroid
Cholera
Diarrheal disease epidemic
Diphtheria
Encephalitis
Gonococcal infection in a person less than 14 years of age
Granuloma inguinale
Hansen's disease (leprosy)
Influenza
Lymphogranuloma venereum
Measles (rubeola)
Ornithosis (Psittacosis)
Pertussis (whooping cough)
Plague
Polio, paralytic or non-paralytic
Rabies (human)
Rubella (including congenital)
Shigellosis
Smallpox (including vaccinia)
Syphilis
Tetanus
Trichinosis
Tuberculosis
Tularemia
Typhoid fever
Typhus
Illness occurring in a traveler from a foreign ccuntry

In the event of an outbreak of diarrheal disease, influenza, or measles, analysis of specimens from each case is unnecessary after the disease organism is determined by the department. A laboratorian or any other person in possession of a specimen from a case of a disease listed must submit it to the local health officer upon request. If no specimen from the case is otherwise available and the case refuses to allow a specimen to be taken, the case will be assumed to be infected and must comply with whatever control measures are imposed by the department or local health officer. A physician or laboratorian performing a blood test which shows the presence of the antibody to the human immuno-deficiency virus (HIV) must submit to the department laboratory a blood specimen from the person tested in order to confirm the test results.

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Volume: 12:3 **Month of:** MARCH - 1988

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Beaverhead				2											
Big Horn				5											
Blaine												2			
Broadwater															
Carbon												3			
Carter															
Cascade				3			1	1				1			
Chouteau															
Custer															
Daniels															
Dawson				1											
Deer Lodge				1											
Fallon												1			
Fergus											1	9			
Flathead	1			2											
Gallatin				3			1								
Garfield												1			
Glacier			1	4											
Golden Valley												1			
Granite															
Hill											1	3			
Jefferson															
Judith Basin															
Lake				1											
Lewis & Clark			1			1								1	
Liberty															
Lincoln								1							
McCone															
Madison															
Meagher															
Mineral															
Missoula	1		1	1							1		2		
Musselshell			1									1	1		
Park					1										
Petroleum															
Phillips															
Pondera												2			
Powder River															
Powell															
Prairie															
Ravalli															
Richland															
Roosevelt				5								1			
Rosebud													2	2	
Sanders															
Sheridan															
Silver Bow			7	1											
Stillwater															
Sweet Grass															
Teton															
Toole												1			
Treasure															
Valley							1								
Wheatland															
Wibaux															
Yellowstone				8		1	2					3			
MONTHLY TOTAL 1988	2	*168*	11	37	1	2	5	2	0	0	3	29	5	3	0
MONTHLY TOTAL 1987	0	104	17	27	2	6	4	3	1	0	10	13	3	3	3
MONTHLY TOTAL 1986	1	37	6	63	4	2	1	1	1	0	25	14	10	3	11
TOTAL TO DATE 1988	7	568	44	106	4	16	15	3	2	0	19	63	13	15	0
TOTAL TO DATE 1987	1	317	33	138	7	14	10	5	1	0	15	43	9	11	8
TOTAL TO DATE 1986	13	94	22	168	8	16	10	2	2	4	32	62	15	7	5

OTHER DISEASES: Amebiasis: Flathead, 1; Aseptic Meningitis: Glacier, 1; Chickenpox: Cascade, 24; Dawson, 1; Gallatin, 2; Judith Basin, 10; Lake, 14; Silver Bow, 22; Yellowstone, 2; Cytomegaloviral illness: Fergus, 1; Hib Invasive Disease: Flathead, 1; Pertussis: Lewis and Clark, 1

* Breakdown by county not available for month of March.

FREE!! The Montana Immunization Program has one large refrigerator with freezer unit, one small refrigerator and one small chest freezer for loan to be used to store project vaccine. These are available on a first-come, first-serve basis, and recipient must arrange for shipping. Call the Immunization Program at 444-4740.

* * * * *

HIV COUNSELOR TRAINING

The Montana Department of Health and Environmental Sciences, Helena, Montana will sponsor an HIV-Antibody Test Counselor Training, June 7-8, 1988, 8:30 - 5:30 p.m. The workshop will be held at Merillac Hall, Saint Vincent Hospital and Health Center, 1233 N. 30th, Billings, Montana. No fees will be charged for this presentation. The purpose of training is to ensure that persons receiving HIV antibody tests are appropriately counseled so that an informed choice is made to be tested; and to ensure that appropriate and accurate information is given regarding test results. For additional information, contact: Marsha McFarland and Andrea Baumgardner, MDHES AIDS Program, 406-444-4740.

Important Information Forms for DTP/DT/Td (diphtheria, tetanus and pertussis) vaccines and MMR (measles, mumps and rubella) vaccines have been revised as of 1/88. Please begin using the revised forms immediately. If you need a supply of new forms, contact the Montana Immunization Program at 444-4740. Revised forms in foreign languages (Spanish, Vietnamese, Chinese, and French) will be available after June 15th.

The foreign forms are not available in bulk, but we would be happy to send you camera-ready copies.

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APRIL 1988

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		3									1	1			
Blaine		1										1			
Broadwater															
Carbon												1			
Carter															
Cascade		12		8											
Chouteau															
Custer		1													
Daniels															
Dawson		1		1											
Deer Lodge															
Fallon															
Fergus		2									1	5			
Flathead		5		5											
Gallatin	1	17	2	2									1	2	
Garfield															
Glacier		5		8										1	
Golden Valley												2			
Granite															
Hill		7					1								
Jefferson															
Judith Basin															
Lake		2		2											
Lewis & Clark		12		2		1							1		
Liberty		1													
Lincoln		1													
McCone												2			
Madison															
Meagher															
Mineral		1													
Missoula	3	15	1	2			3						1	1	
Musselshell													1		
Park							1								
Petroleum															
Phillips		1										1			
Pondera												3			
Powder River												1			
Powell															
Prairie															
Ravalli		4													
Richland															
Roosevelt		6	1	7								3			
Rosebud		6		10										1	
Sanders															
Sheridan															
Silver Bow		6													
Stillwater		1													
Sweet Grass								1							
Teton															
Toole											4	3			
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone		22		8					1			4	3		
MONTHLY TOTAL 1988	4	134	4	52	0	1	5	1	1	0	6	27	7	5	0
MONTHLY TOTAL 1987	1	132	17	44	0	8	9	1	0	0	9	25	2	0	0
MONTHLY TOTAL 1986	5	62	15	63	6	8	6	1	4	1	7	41	3	2	2
TOTAL TO DATE 1988	11	702	48	158	4	17	20	4	3	0	25	90	20	20	0
TOTAL TO DATE 1987	2	449	50	182	7	22	17	6	1	0	24	68	11	11	8
TOTAL TO DATE 1986	18	156	37	231	14	24	16	3	6	5	39	103	18	9	7

OTHER DISEASES: Aseptic Meningitis: Yellowstone, 1; Chickenpox: Cascade, 37; Flathead, 5; Yellowstone, 16; Malaria: Flathead, 1; Mumps: Yellowstone, 2; Syphilis: Lincoln, 1 early latent <1 year; Yersiniosis: Gallatin, 1

Tick season is here. This Spring, Montana Department of Health and Environmental Sciences Public Health Laboratory has received many specimens for analysis relative to suspected tick-borne diseases. In fact, cases of both Colorado Tick Fever and Rocky Mountain Spotted Fever reported in May 1988 are greater than cases reported in May 1987 (see table below):

Comparison of Reported Cases of Tick Fevers
in Montana May 1988 and 1987

Disease	May 1988	May 1987
Colorado Tick Fever	6	2
Rocky Mountain Tick Fever	3	1

Preventive Health Services Bureau is investigating the possibility of endemic Lyme Disease occurring in Montana.

Tick diseases can be prevented by practicing "tick hygiene". Ken Quickenden, Ph.D., MDHES entomologist suggests the following and you may want to pass these tips on to your community.

-- Avoid areas known to be infested with ticks if possible.

-- When in an infested area, wear clothing which fits snugly around ankles, wrists and waist -- not shorts or short-sleeved shirts.

-- Keep upper layers of clothing tucked into lower layers -- pants into tops of long socks, shirts into trousers. Layering clothing also tends to help.

-- Clothing can be treated with repellants, such as diethyltoluamide or dimethl phthalate, to provide some protection from ticks. The military clothing impregnant M-1960 is also effective, he said. However, applying repellants directly to the skin provides very little protection.

-- Examine yourself and children at least twice a day to locate and remove ticks. Check hair, scalp and body crevices thoroughly. Pets should also be checked.

-- If a tick is found, remove it immediately, by pulling gently, slowly and carefully to avoid leaving the head of the tick under the skin.

   If the head does not come out with the rest of the body, remove it as you would a splinter, he said.

   Try not to crush the tick as secretions are potentially ineffective. Protect hands by using tweezers, paper, cloth or gloves.

-- After the tick is removed, wash the bite area and paint it with an antiseptic, then wash hands, tweezers, gloves, etc.

-- Physicians who would like to have laboratory support in diagnosis of tick-borne diseases can contact Suzie Zanto at 444-2642.

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Volume: 12:6 **Month of:** May 1988

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MAY
1988

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		1	1	1									1	10	
Blaine		3										1			
Broadwater															
Carbon		1													
Carter															
Cascade		16	1	6		1	1					1	1		
Chouteau		1													
Custer		2													
Daniels												1			
Dawson				1											
Deer Lodge		3													
Fallon															
Fergus		1										7			
Flathead		7		1		1									
Gallatin	1	25	2	1								1	1		
Garfield												1			
Glacier		6		2							1			2	
Golden Valley															
Granite															
Hill		10	1									1	1		
Jefferson															
Judith Basin															
Lake		3		2				1							
Lewis & Clark		8		1									1	1	
Liberty															
Lincoln		6													
McCone															
Madison		1													
Meagher															
Mineral															
Missoula	1	18	6	2			2						1		
Musselshell												1			
Park															
Petroleum															
Phillips		1													
Pondera		2													
Powder River												2			
Powell		1									1				
Prairie															
Ravalli				1											
Richland		3		1								1			
Roosevelt		12	2	8								1			
Rosebud		3		3								1		6	
Sanders						1									
Sheridan												1			
Silver Bow		10				1							2	1	
Stillwater		4													
Sweet Grass															
Teton	1														
Toole												1			
Treasure															
Valley															
Wheatland															
Wibaux		1													
Yellowstone	1	35		5			1	1				2			
MONTHLY TOTAL 19 88	4	184	13	35	0	4	4	2	0	0	2	23	8	20	0
MONTHLY TOTAL 19 87	6	144	8	41	2	5	8	1	1	0	19	18	11	0	0
MONTHLY TOTAL 19 86	2	81	8	59	3	2	4	0	1	2	11	23	3	0	1
TOTAL TO DATE 19 88	15	886	61	193	4	21	24	6	3	0	28	113	28	40	0
TOTAL TO DATE 19 87	8	593	58	223	9	27	25	7	2	0	43	86	22	11	8
TOTAL TO DATE 19 86	20	237	45	290	17	26	20	2	7	7	50	126	21	9	30

OTHER DISEASES: Chickenpox: Cascade, 19; Dawson, 1; Flathead, 28; Judith Basin, 2; Lake, 3; Yellowstone, 126; Colorado Tick Fever: Gallatin, 1; Lewis & Clark, 1; Missoula, 2; Ravalli, 2; Rocky Mountain Spotted Fever: Musselshell, 1; Park, 1; Ravalli, 1; Strep Pneumo Meningitis: Cascade, 1

DELAYED REPORTS: 1 Post-exposure rabies treatment in March for Fergus County

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WHAT TO DO IF A FOOD HANDLER IS SUSPECTED OF HAVING HEPATITIS A

Several states in the northwest and southern United States which have many Montana visitors issued news releases this Spring to alert patrons of restaurants they may have been exposed to Hepatitis A by a food handler. Several Montana cities had situations arise where they had food handlers with a presumptive diagnosis of Hepatitis A and consulted Montana Department of Health and Environmental Sciences (MDHES) concerning a plan of action. Although each situation must be evaluated and dealt with when it arises, it is possible to have a plan in place to do such an evaluation. When it is suspected a person preparing food for others has Hepatitis A the following steps should be taken:

(1) Remove the person from any food handling situation(s) until the diagnosis is confirmed and/or the worker is determined to be noninfectious.

(2) Confirm the diagnosis with laboratory testing as quickly as possible. The test can be done within a matter of hours of receipt by a laboratory capable of doing the testing. Avoid delays by promptly drawing and mailing the specimen and personally talking to the laboratory regarding their capability to do the analysis in a timely manner before sending it to them.

(3) Evaluate the food handlers work practices and hygiene. Workers who handle cold food with bare hands may have contaminated food served to others. Other workers (cooks, servers, dishwashers) who don't put their hands on the food after cooking should not be in a position to transmit the virus.

(4) Determine the likely period of infectiousness for the food handler. Shedding of virus in stool doesn't occur beyond the 5th day of jaundice. The two weeks prior to jaundice onset is the period in which stool shed virus is most prevalent.

(5) Work with the manager of the food establishment to educate him/her and elicit cooperation. Other food handlers who work with the suspect case should immediately be evaluated concerning the need for receipt of immune serum globulin and/or signs and symptoms of illness.

(6) When a confirmation of Hepatitis A is made for the suspect case, decide, based on the above steps whether or not the public needs to be alerted. If the decision is made the public should be alerted, inform the restaurant owner and have a plan to answer questions, give immune serum globulin, make referrals or whatever else is warranted.

Anyone wishing assistance with any of the above steps is encouraged to phone the Preventive Health Services Bureau, Communicable Disease Section at 444-4740.

Prepare Now for Influenza Vaccination Programs

The Immunization Practices Advisory Committee recommendation for Influenza vaccination programs for 1988-1989 were printed in the Morbidity and Mortality Weekly Report issue dated June 17, 1988. The Centers for Disease Control, 1988 Immunization Conference held in San Antonio, Texas, June 20-24, 1988, contained many sessions and presentations illustrating the need for the U.S. to improve Influenza Vaccine delivery. Seven dollars in health care costs are saved for every one dollar spent on Influenza vaccine. In 1985, only 17% of high risk persons needing Influenza vaccination in this country received it. Planning for Influenza vaccination programs must begin now so vaccine delivery can occur beginning in September in high-risk persons presenting for other health care. Don't miss these "missed opportunities". Nursing home programs should probably occur in October in Montana. More information about Influenza Prevention will appear in the next issue of this publication. The toll-free number for ordering Influenza vaccine using the State term contract is 714-521-7050.

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JUNE
1988

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		2					1					3		4	
Blaine		3		1											
Broadwater															
Carbon	1											1			
Carter															
Cascade		18		7				1					1		1
Chouteau	1														
Custer		2					1				2	1			
Daniels															
Dawson							1								
Deer Lodge		3	1												
Fallon			1								1				
Fergus		1										1			
Flathead		7									1				
Gallatin		25	2		1										
Garfield															
Glacier		8		2											
Golden Valley												1			
Granite															
Hill		7		1											1
Jefferson															
Judith Basin												1			
Lake		4	1				1								
Lewis & Clark		12	2										1		
Liberty															
Lincoln		5													
McCone												1			
Madison							1								
Meagher															
Mineral		1													
Missoula	1	12	1	1								1			
Musselshell		1										2			
Park		2	1	2											
Petroleum															
Phillips															
Pondera												1			
Powder River															
Powell	1														
Prairie															
Ravalli		2													
Richland															
Roosevelt		8		6											1
Rosebud		3		2								1	1		
Sanders															
Sheridan															
Silver Bow	1	8	7		1										1
Stillwater	1														
Sweet Grass							2								
Teton															
Toole											1				
Treasure												1			
Valley															
Wheatland															
Wibaux		1													
Yellowstone	2	27	4	6									1		1
MONTHLY TOTAL 1988	8	164	20	28	2	0	7	1	0	0	5	15	4	4	5
MONTHLY TOTAL 1987	6	144	9	60	2	8	3	0	1	2	16	14	6	2	1
MONTHLY TOTAL 1986	12	55	16	64	2	1	6	2	1	0	10	15	0	1	3
TOTAL TO DATE 1988	23	1050	81	221	6	21	31	7	3	0	33	128	32	44	5
TOTAL TO DATE 1987	14	737	67	283	11	35	28	7	3	2	58	100	28	13	9
TOTAL TO DATE 1986	31	292	61	354	18	28	25	4	7	7	59	141	21	10	11

OTHER DISEASES: *AIDS: Yellowstone, 1; Out-of-state, 1; Chickenpox: Big Horn, 6; Cascade, 7; Flathead, 4; Lake, 2; Silver Bow, 9; Wheatland, 3; Yellowstone, 47; Colorado Tick Fever: Deer Lodge, 1; Missoula, 1; Ravalli, 1; Malaria: Yellowstone, 1; Measles, Imported: Lincoln, 1; Ornithosis: Dawson, 2; Early Syphylis: Cascade, 2

DELAYED REPORTS: *AIDS:
Jan.; Yellowstone, 1; Silver Bow, 1
Feb.; Missoula, 1
Mar.; Cascade, 1
Apr.; Out-of-state, 1

*AIDS cases are reported by place of diagnosis rather than county of residence.

Influenza Important Information Form Available

The 1988-89 Influenza season recommendations are now available. Important Information forms used to inform recipients of risks and benefits of the vaccine were developed by Centers for Disease Control. Montana Department of Health and Environmental Sciences (MDHES) has a white reproducible copy and will provide one to anyone wishing it. If you wish to obtain one white copy, contact the Immunization Program by phoning 444-4740 or by writing to Cogswell Building, Helena, Montana 59620.

Return Vaccine Shipping Containers

Please return styrofoam coolers, cardboard sleeves and refreezable ice packs you have received from the Immunization Program when ordering vaccine. There are many containers and ice packs out and we must be prepared for your Fall orders. Charges for non-returned containers and coolant packs can be levied if the items are not returned to MDHES.

Correction on 1987 Annual Summary

The total number of chickenpox cases was incorrectly stated as 864. The correct number of cases was 874, with the addition of 10 more cases in Cascade County. The correct total for that county would then be 53.

Measles in Park and Gallatin County

As of August 9, 1988 21 cases of measles (Rubeola) have occurred with 1 case in Gallatin County and 20 cases in Park County. The index case was an international visitor to the Corwin Springs area. All cases have been unimmunized persons, mostly children. There have been 8 cases in the first generation, 9 cases in the second and to date there have been 3 cases reported at the start of the third generation. Travellers planning to visit the Park County area should be aware of measles occurring there. The Immunization status of persons planning to travel should be checked before departure to the area. Those not able to verify immunity should be vaccinated. Children less than 15 months of age should not be exposed to measles.

Shigellosis Outbreak

102 cases of Shigellosis have been reported to Montana Department of Health and Environmental Sciences (MDHES) as of August 8, 1988 for this calendar year. This compares with a total of 42 cases in 1987, 27 cases in 1986 and 53 cases in 1985. Counties reporting cases of Shigellosis in 1988 are as follows:

County Name		Number of Cases	Frequency
Big Horn	=	68	66.7%
Deer Lodge	=	1	1.0%
Gallatin	=	4	3.9%
Glacier	=	4	3.9%
Lewis and Clark	=	2	2.0%
Missoula	=	1	1.0%
Ravalli	=	1	1.0%
Rosebud	=	19	18.6%
Silver Bow	=	1	1.0%
Yellowstone	=	1	1.0%

Both S. flexneri and S. sonnei have been isolated indicating there are two outbreaks occurring simultaneously. Sero-typing of Shigella isolates is available from MDHES Public Health Laboratory. If you have questions regarding collection, handling of or submission of specimens, call the Public Health Laboratory at 444-2642.

Occurrence of E. coli 0157:H7

Escherichia coli 0157:H7 is a recently recognized cause of bloody diarrhea and Hemolytic-Uremic Syndrome (HUS). This pathogen has been associated with contaminated food; hamburger has been implicated as the most common source. The Montana Public Health Laboratory routinely tests for the presence of this organism in all stools which are screened for Salmonella/Shigella. Two cases of E. coli 0157:H7 were found in the month of July, 1988; no other cases have been reported this year.

One case had HUS, the other had only bloody diarrhea. The source of these two cases has not as yet been determined.

Practitioners should be aware that this organism is a potential cause of bloody diarrhea and HUS, and that special testing methods are required. Contact the Public Health Laboratory for information regarding test protocols or specimen submission.

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JULY
1988

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead															
Big Horn		6	2	3									2	43	
Blaine		2													
Broadwater	1	1	1												
Carbon															
Carter															
Cascade		20	1	4								4			
Chouteau															
Custer		2		1											
Daniels															
Dawson	1	3		1											
Deer Lodge		1	2										1		
Fallon															
Fergus												1	1		
Flathead		10		3			1				1				
Gallatin	3	16	3	1		1					1				
Garfield		1									8	1			
Glacier		7		4										1	
Golden Valley															
Granite															
Hill		7		1									1		
Jefferson			1												
Judith Basin															
Lake	1	2													
Lewis & Clark		9	1	1								1	2		
Liberty															
Lincoln		5													
McCone															
Madison													1		
Meagher															
Mineral															
Missoula	5	11	4	2		2									
Musselshell											3	1			
Park				1			1								
Petroleum															
Phillips		1													
Pondera			1												
Powder River															
Powell															
Prairie															
Ravalli	3														
Richland										1					
Roosevelt		8		7								1	1		
Rosebud		2												3	
Sanders		1		1											
Sheridan		1													
Silver Bow	1	5	2	3								1			
Stillwater															
Sweet Grass		1													
Teton															
Toole											1	2			
Treasure															
Valley	1												1		
Wheatland												1			
Wibaux															
Yellowstone	1	19	1	8		1		1				2	2		
MONTHLY TOTAL 1988	17	141	19	41	0	4	2	1	0	1	14	15	12	47	0
MONTHLY TOTAL 1987	6	176	12	60	0	14	6	0	0	1	14	9	5	3	0
MONTHLY TOTAL 1986	13	48	27	71	1	22	8	0	0	1	16	8	5	1	5
TOTAL TO DATE 1988	40	1191	100	262	6	25	33	8	3	1	47	143	44	91	5
TOTAL TO DATE 1987	20	913	79	343	11	49	34	7	3	3	72	67	33	16	9
TOTAL TO DATE 1986	44	340	88	425	19	50	33	4	7	8	75	150	26	11	16

OTHER DISEASES: Chickenpox: Cascade, 1; Flathead, 4; Hill, 3; Wheatland, 10; Yellowstone,21
Colorado Tick Fever: Madison, 1; Yellowstone, 1; Malaria: Park, 1; Yellowstone, 1;
Measles, imported: Gallatin, 1; Park, 14; Rocky Mountain Spotted Fever: Big Horn, 1;
Cascade, 1; Sheridan, 1 Syphilis, early latent 1yr: Roosevelt, 1; Yellowstone, 1;
Syphilis, secondary: Yellowstone, 1

Testing of Tuberculosis Patients for HIV Antibody

HIV testing of all TB patients should be considered because of the implications of HIV seropositivity for patient management. There is some evidence that TB patients with HIV infection do not respond to standard therapies as well as patients without HIV infection. Some reports have suggested a higher incidence of adverse drug reactions and a higher treatment-failure rate during therapy. Therefore, CDC and the American Thoracic Society have recommended a more aggressive approach to treatment of TB in HIV-infected patients. Treatment should initially include at least three of the drugs available for treatment of TB, should continue for a minimum of 9 months, and should last for at least 6 months after the patient becomes negative for M. tuberculosis. HIV-infected patients with tuberculosis should receive frequent and careful monitoring for adverse drug effects during therapy and should be periodically evaluated for signs of relapse after therapy is complete. To prevent the transmission of HIV, persons being tested for HIV infection should be counseled in accordance with current recommendations.

Patients with AIDS or HIV infection who also develop TB often have clinical findings* that are different from those of TB patients without immunodeficiency and a high index of suspicion and special diagnostic studies are often needed to establish the diagnosis of TB in these patients. HIV-infected persons who have active TB should be treated in accordance with recently published guidelines. Those guidelines were published in the MMWR 1986, Volume 35, pages 448-457.

Available data suggest that the number of patients known to have both tuberculosis and AIDS may represent only a small proportion of patients with tuberculosis who are infected with HIV. HIV infection, when acquired by a patient with latent tuberculosis infection, seems to allow the progression to overt clinical tuberculosis. Epidemiologic investigations and HIV seroprevalence surveys among patients with tuberculosis will enable investigators to determine the full extent to which HIV is responsible for the increase in tuberculosis morbidity.

Because HIV infection appears to be a significant risk factor for developing tuberculosis, CDC has recommended that HIV-infected individuals be given a tuberculin skin test. Although some HIV-infected persons may be anergic, a positive test is meaningful. Because of the risk of developing tuberculosis, HIV-infected persons who have or have had a positive tuberculin skin test should receive preventive therapy with isonazid after active tuberculosis has been ruled out, regardless of their age. All patients with risk factors for tuberculosis and AIDS should be routinely counseled and tested for HIV antibody. HIV testing of other patients with tuberculosis should also be considered because of the implications of HIV seropositivity for patient management.

*Multiple disease sites, extrapulmonary involvement, loss of tuberculin skin reactivity, and among patients with pulmonary disease, noncavitary chest X-rays.

JSI REGION VIII TRAINING:
STDS - A TO Z (ALMOST) COUNSELING, EDUCATION AND A CLINICAL UPDATE.
October 6 & 7, 1988, Helena, Montana

This workshop, designed to provide an update on sexually transmitted diseases, will include a clinical update and counseling information. There will also be information on what is new, advances and developments in this area of health care. Chlamydia and the projects that are on-going will be discussed. Cervical cancer as an STD will be included in this workshop with discussion about Pap smears and laboratories.

As the Medical Coordinator for King County Public Health Department (Seattle, WA), VIVIEN HANSEN is a Family Practice Physician. It is a pleasure and an honor for JSI to sponsor Dr. Hansen for this training workshop in Montana.

This workshop will be held at the Colonial Inn located at 2301 Colonial Drive, Helena, MT 59620. For more information call the Montana State Family Planning Program at (406) 444-3609.

* * * * * * * * * * * * * * * * * * *

The Department of Health and Environmental Sciences will sponsor Counselor Training for providers of the HIV Antibody Test November 1 and 2 at the Village Red Lion Inn in Missoula.

The course is targeted for health care or allied professionals who will be administering HIV antibody tests and informing individuals tested of test results. Enrollment is limited to 20 and will be on a first-come, first-serve basis.

There is no charge for attendance at the 2-day seminar, however DHES requests that agencies which send personnel for training agree to send basic testing data and demographic information to the MDHES AIDS Program.

To register for the course, or for more information, contact Marsha McFarland or Andrea Baumgardner at 444-4740.

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AUGUST 1988

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		4													
Big Horn		8		1										30	1
Blaine		1	1	1											
Broadwater	1														
Carbon		1											1		
Carter												1			
Cascade		20	2	4			1	1					1		
Chouteau		1		1											
Custer		1													
Daniels															
Dawson															
Deer Lodge		1	3											1	
Fallon		1									1				
Fergus		1		1								1	1		
Flathead		7					1				1	1			
Gallatin		18	2	1							1				
Garfield		1										3			
Glacier		13		4										1	
Golden Valley															
Granite												1			
Hill	1	5		1											
Jefferson		4	2										1		
Judith Basin												1			
Lake		4					1								1
Lewis & Clark		8	1	1							1				
Liberty															
Lincoln		2				1									
McCone												1			
Madison	1						1								
Meagher															
Mineral				1											
Missoula	4	5	7	1	1						1		3		1
Musselshell	1											2	3		
Park		3													
Petroleum															
Phillips		1		2											
Pondera															
Powder River		1													
Powell		1	1												
Prairie															
Ravalli		3	1												
Richland													1		
Roosevelt		10		4								1		1	2
Rosebud				1							1		2	2	
Sanders															
Sheridan															
Silver Bow		7													
Stillwater											3				
Sweet Grass												1			
Teton		1													
Toole															
Treasure															
Valley													1		
Wheatland															
Wibaux															
Yellowstone	2	37	1	3			1					4	4	1	2
MONTHLY TOTAL 1988	10	170	21	27	1	1	5	1	0	0	9	17	18	36	7
MONTHLY TOTAL 19	7	201	11	60	0	14	3	2	0	0	8	15	16	4	0
MONTHLY TOTAL 19	5	51	20	63	1	6	5	1	1	0	13	11	8	1	3
TOTAL TO DATE 19	50	1361	120	289	7	26	37	9	3	1	56	160	61	127	12
TOTAL TO DATE 19	27	1114	90	403	11	63	37	9	3	3	79	82	49	20	9
TOTAL TO DATE 19	49	391	108	488	20	56	38	5	8	8	88	161	34	12	19

OTHER DISEASES: Chickenpox: Cascade, 1; Colorado Tick Fever: Beaverhead, 3; Gallatin, 1; Ravalli, 2; Yellowstone, 1; Hib Invasive Disease: Cascade, 1; Legionellosis: Ravalli, 1; Measles, indigenous: Park, 5; Measles, imported: Park, 3; Early Latent Syphilis 1 year: Roosevelt, 1; Yellowstone, 1

DELETED REPORTS: (deleted from 1988 yearly totals) Campylobacter: Missoula, 1; Hepatitis B: Sweetgrass, 1; Giardia: Big Horn, 1; Salmonellosis: Yellowstone, 1

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Montana Epidemiology Report

Montana State Department of Health and Environmental Sciences

GONORRHEA TRENDS IN MONTANA

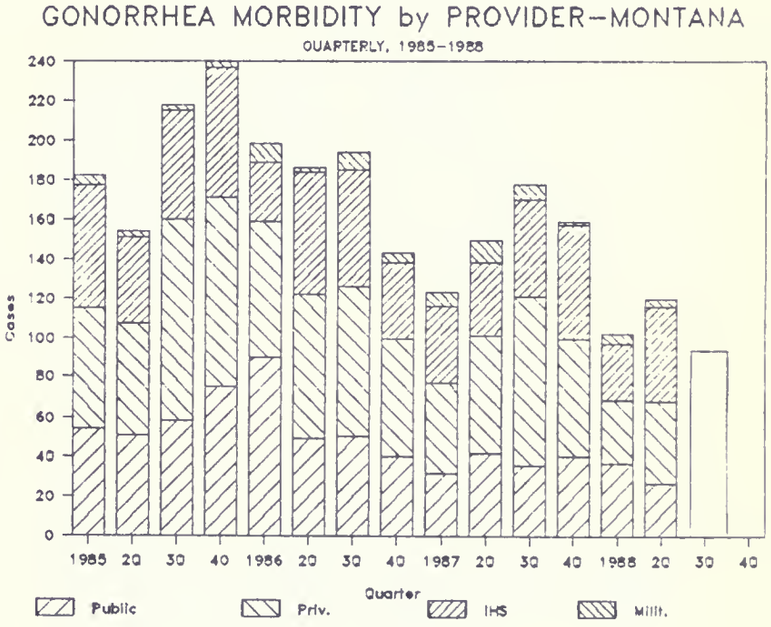
Gonorrhea morbidity in Montana has continued to decline from the peak of 2,197 cases in 1978 to 619 cases reported in 1987. The recent incidence rate of 78 cases/100,000 population is within the 1988 goal set of 85 cases per 100,000 and is on target for our 1993 goal of reducing incidence to 50 cases/100,000. This compares with the national incidence rate for 1987 of 310 cases/100,000. The largest decrease in cases occurred in the public sector, which includes local health departments, family planning clinics, and university health service. (See graph below.)

Some of our objectives to further reduce GC morbidity in Montana and prevent the adverse health effects associated with it, include:

- o Insuring 90% of all uncomplicated gonorrhea cases are interviewed within five days of the report.
- o Insure 90% of new GC contacts are examined and/or treated within seven days of the interview.
- o Maintain elimination of indigenous resistant gonorrhea by insuring testing of all positive cultures and following-up/interviewing any resistant cases within 48 hours of the report.
- o Reduce incidence of gonococcal PID to 10 cases/100,00 women in Montana, by interviewing 95% of gonococcal PID patients, 75% within five days of the patient visit. To insure a test of cure on 85% of these patients and refer 75% of their contacts (often without symptoms) in for examination/treatment within seven days of the interview.

One of the tools we have to document that these goals are met is our STD Interview Case Record, developed here in 1987. We are simplifying the instructions for use of that form, to make it easier to use and to be able to provide better information to local agencies on their efforts to provide intervention, prevention services for these patients.

GONORRHEA MORBIDITY by PROVIDER—MONTANA



MONTANA TUBERCULOSIS

Since 1979 there have been no separate distinct funds for Tuberculosis control in the Montana State Department of Health and Environmental Sciences. Tuberculosis activities were absorbed by the Communicable Disease Control Program.

The past and current Field Health Officers have been trained in the pathogenesis and control methods for t.b. Consultation, monitoring the incidence of disease and provision of medication to cases in conjunction with the Department of Institutions have become the main role the Department has played in Tuberculosis control in the past few years.

The cases of Tuberculosis reported for the years 1979 to the present are as follows:

1. 1979 - 41
2. 1980 - 27
3. 1981 - 35
4. 1982 - 37
5. 1983 - 47
6. 1984 - 32
7. 1985 - 50
8. 1986 - 34
9. 1987 - 21

Prior to 1981, the number of newly reported cases of Tuberculosis had been occurring at a rate of at least 4% less each year than the previous and this is consistent with an effective control program being in place. This has not been consistently maintained since 1979.

As of this date, September 22, 1988, we have 60 tuberculosis cases and suspect cases in the registry. Some of these may not become cases and the registry may still have some cases diagnosed in another year although with 9 month therapy being the usual, most diagnosed in 1987 or earlier should now be done.

CDC has developed a t.b. elimination plan. Indian Health Service is currently embarking on a plan for targeting some high incidence areas. MDHES is concerned because several clusters of cases have occurred in some localities which may indicate there is even more Tuberculosis occurring than being reported. **TUBERCULOSIS IS STILL OCCURRING IN MONTANA.** It is being transmitted to children and this can ensure continuation of the disease into future decades.

The American Thoracic Society guidelines related to diagnosis and treatment of Tuberculosis need to be employed. Copies are available from the Communicable Disease Section of MDHES by calling 444-4740 or writing to the program, Cogswell Building, Helena, MT 59620.

American Thoracic Society guidelines discuss work-up of a case including the following elements:

1. Tuberculin skin test.
2. Chest x-ray.
3. Microbiological specimen submission for smear and culture.
4. Physical assessment.

All these elements are important in diagnosis but they also are a baseline for determining effectiveness of treatment and the need for contact testing. For example, a smear positive person is likely to have infected more persons than a pulmonary t.b. case with a negative sputum smear. Therefore, the contact investigation probably needs to be more extensive for the smear positive patient. Mycobacterial disease processes caused by organisms other than M. t.b. are not considered to be communicable so when a culture indicates the causative organism is other than M. t.b. or "atypical" public health efforts should be redirected towards Mycobacterium tuberculosis smear and culture positive cases and/or cases more surely infected with t.b.

MMWR ERROR

Please note that the MMWR Vol. 37, No. 12, April 1, 1988 should be amended as follows: (Page 1 and the fifth paragraph of the 8½" version):

p. 182 The first two sentences of the first paragraph should read: "Immune globulin (IG) (16.5 gm% protein) can be used to prevent or modify measles infection in HIV-infected persons if administered within six days of exposure. IG is especially indicated for measles-susceptible household contacts with asymptomatic HIV infection, particularly for those under one year of age, and for measles-susceptible pregnant women."

SEPTEMBER 1988	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		3											1	23	
Blaine		1													
Broadwater															
Carbon															
Carter											1				
Cascade		12	15	3				1					3		1
Chouteau													1		
Custer		4										1			
Daniels															
Dawson		3													
Deer Lodge		1	3	1											
Fallon															
Fergus		1	2				1				2	2			
Flathead	3	7	1	1							3	2			
Gallatin		11	4				1						1		
Garfield											1	2			
Glacier		12	2	5							3		1	4	
Golden Valley												1			
Granite															
Hill		6	1	1										1	
Jefferson			1												
Judith Basin	1											2			
Lake			1									1			
Lewis & Clark		16	2	1			2						1		1
Liberty															
Lincoln	1	2													
McCone															
Madison															
Meagher															
Mineral		1													
Missoula	3	14	4	1	1						2	1	1		
Musselshell		1													
Park		1	1								1		1		
Petroleum															
Phillips															
Pondera															
Powder River															
Powell															
Prairie															
Ravalli						1							1		
Richland				1											
Roosevelt		5	1	5		2								2	
Rosebud		5		1							1				1
Sanders															
Sheridan			3												
Silver Bow	2	5													
Stillwater											1				
Sweet Grass															
Teton			1												
Toole				1											
Treasure															
Valley	1								1						
Whestland															
Wibaux															
Yellowstone	1	27	5	6		1	2						3	4	
MONTHLY TOTAL 1988	12	140	47	27	1	4	6	1	1	0	15	12	14	34	3
MONTHLY TOTAL 1987	2	142	21	56	1	7	4	0	1	1	5	13	10	3	1
MONTHLY TOTAL 1986	4	72	43	60	0	7	3	1	0	0	9	8	11	0	4
TOTAL TO DATE 1988	62	1501	167	316	8	30	43	10	4	1	71	172	75	161	15
TOTAL TO DATE 1987	29	1256	111	460	12	70	41	9	4	4	84	95	59	23	10
TOTAL TO DATE 1986	53	432	151	548	20	63	41	6	8	8	97	169	45	12	23

OTHER DISEASES: Aseptic Meningitis: Gallatin, 1; Amebiasis: Missoula, 1; Chickenpox: Glacier, 1; Hill, 2; Yellowstone, 3; Colorado Tick Fever: Madison, 1; Hib Invasive Disease: Dawson, 1; Lyme Disease: Silver Bow, 1; Malaria: Missoula, 1; Pertussis: Missoula, 1; Syphilis, Late Latent: Yellowstone, 1

EDUCATION

Workplace Training Guide Published

A new and innovative primer for AIDS education in the workplace has been published by the American Foundation for AIDS Research, the American Council of Life Insurance, and the Health Insurance Association of America. The guide provides a detailed plan for developing quality AIDS education without "reinventing the wheel" or spending scarce training dollars inefficiently.

Developed for use by companies of all sizes, the guide presents information on the impact of AIDS on business and society, and includes a chapter that outlines how to run an AIDS education employee program. It includes listings of videotapes and other educational materials that are available at no charge.

For complimentary single copies, send a request on company letterhead to the American Foundation for AIDS Research (AmFAR), 1515 Broadway, Suite 3601, New York, NY 10036. Multiple copies of the book are available at $5.00 per copy.

National Sheriff's Association Develops Model Policies

The National Sheriff's Association (NSA) will develop and implement a national training and technical assistance program for criminal justice practitioners demonstrating a need for AIDS-related information. The work will be completed in two phases; the goal of the first is to assess current training needs and to collect and evaluate existing policies and training curricula from state criminal justice training agencies, state sheriffs' associations, and state departments of correction. During phase two, NSA will develop appropriate model policies for agencies managing high-risk populations and formal training curricula for trainers and practitioners. The "performance oriented" model policies and procedures will seek to change the behavior of practitioners by recommending specific tasks in response to offenders with HIV. Thus, trainers' materials will be developed based on actual tasks that agency staff will be expected to perform, with objectives clearly delineated for each task.

In addition, during phase two of the project, NSA staff will conduct four pilot training programs to test the curricula. These will be followed by on-site training for key policy and operational personnel in agencies demonstrating such needs.

Requests for information and/or technical assistance may be directed to Anna Laszlo, Project Director, or Theresa Seemiller, Technical Assistance Coordinator, at 1-800-424-STAR.

TRANSMISSION

"Data on Youths' Promiscuity Stir Concerns on AIDS"

Although a Centers for Disease Control (CDC) report released earlier reported that a survey of sexual habits shows that "most Americans appear to be at relatively low risk of infection" with HIV, the percentage of young men reporting 10 or more sexual partners in the previous year has raised concerns that they may be "at considerable risk." The report suggests that 5 percent of men aged 18-29, or 700,000 single men, reported having 10 or more partners in the previous 12 months. Three percent of the men who reported sexual relations in the previous year said their partners included men, and 6 percent did not answer the question. About 6 percent of the men and 1 percent of the women reported having sex with at least one "casual date or pickup." The National Opinion Research Center interviewed 1,481 people from February 14 to April 25 for the study. Dr. William Darrow, a CDC AIDS specialist, said those who have a high number of partners must be concerned about whether those partners engage in intravenous drug use or homosexual activity. (New York Times - 9/25/88 - p. 31)

CONFERENCES AND WORKSHOPS

The first annual conferences for nurses in AIDS care and inaugural meeting of the Association will be held November 14 and 15 in Baltimore, Maryland. For more information about the meeting, contact the Education and Health Council, Inc., 7201 Rossville Blvd., Baltimore, MD 21237. Phone (301) 686-3610.

TREATMENT AND RESEARCH

Early Intervention is Key to Battling HIV Infection

Washington, D.C.'s Dr. Warren Chamberlain and his associates treat several HIV-positive but asymptomatic men with lower doses of AZT. Chamberlain says some of the "literally dozens" of men receiving AZT as a preventive measure have lowered T-cell counts, but not one has yet developed AIDS. Chamberlain uses the antiviral drug acyclovir in combination with AZT for patients with a history of venereal herpes. The doctor also prescribes aerosolized pentamidine to prevent pneumocystis carinii pneumonia (PCP) in asymptomatic patients with very low T-cell counts. Other doctors offer asymptomatic patients dextran sulfate and egg-yolk derivative AL-721. In San Francisco, Positive Action Health Care, Inc. treats primarily HIV-positive gay men with no symptoms. The clinic includes injected transfer factor, a nonspecific immune-system booster, among its preventive treatment. All the doctors interviewed recommended testing for those at risk, so preventive measures can begin early.

Other doctors interviewed were asked what to do if you test positive for HIV but otherwise feel fine and are asymptomatic. The only suggestion with a clear consensus was that you should take a blood test to measure your T-cell count every three to six months. Although some doctors are using AZT, aycylovir, and aerosol pentamidine in preventive programs, few in three metropolitan areas are taking aggressive action in asymptomatic women. Most doctors said they would use AZT at some point, but only one said he would prescribe it before a patient's T-cell count is below 400. When the T-cell count drops below normal, the doctors mentioned a total of 15 drugs they would consider using. In addition, most doctors recommended a good diet, moderate use or no use of alcohol and reduced stress. Others added vitamin supplements, no sunbathing, and, of course, safe sex. Many said patients should stay abreast of AIDS treatment developments and monitor themselves for symptoms. (Washington Blade - 9/23/88 - Vol. 19, No. 39)

Two New Studies Initiated

On September 19, 1988, FDA gave permission for a large scale trial of an experimental AIDS therapy in children with AIDS Related Complex (ARC) and AIDS. The multi-center study will be sponsored by the National Institute of Allergy and Infectious Diseases, (301) 496-5717, and will eventually involve approximately 250 children age 3 months to 12 years who have this condition.

The controlled study will test whether intravenous immune globulin can help bolster the ability of a child's immune system to fight opportunistic infectious associated with AIDS. In the study, a group of patients receiving a combination of intravenous immune globulin and the approved AIDS drug zidovudine (commonly known as AZT) will be compared to a group treated with zidovudine plus a placebo. This trial will be conducted in conjunction with other on-going clinical studies of zidovudine in children at various stages of AIDS infection.

Since the immune systems of children are generally not fully developed, their reaction to infection with the AIDS virus tends to be far more severe and quickly manifested than the reaction of more mature individuals who have been infected.

On September 16, 1988, FDA gave the go-ahead to a new clinical trial of a combined use of granulocyte macrophage colony stimulating factor, or GM-FSF, and zidovudine in AIDS patients.

GM-CSF stimulates the production of certain blood cells that play an essential role in the body's immune system. Use of GM-CSF with zidovudine might mitigate the latter drug's toxicity.

This dose escalation study, to be conducted by Schering Plough Corp. of Madison, NJ, (201) 298-4000, will involve about 50 AIDS patients.

CURRENT STATISTICS

MONTANA AIDS CASES
Demographic Summary as of 9/15/88

CASES			SEX		
Reported Cases	23	100%	Female	3	13%
Reported Deaths	13	57%	Male	20	87%
				23	100%
AGE			RISK FACTOR		
Less than 5	0	0%	Homosexual/Bisexual Male	12	52%
5-12	0	0%	IV Drug Abuser	3	13%
13-19	0	0%	Homosexual Male & IVDA	2	9%
20-29	6	26%	Hemophilia, etc.	2	9%
30-39	12	52%	Heterosexual	3	13%
40-49	4	17%	Transfusion, Blood Components	0	0%
Over 49	1	4%	No Identified Risk (NIR)	1	4%
	23	100%		23	100%
RACIAL/ETHNIC GROUP			COUNTY OF DIAGNOSIS		
White	19	83%	Cascade	8	35%
American Indian	1	4%	Gallatin	1	4%
Black	1	4%	Lewis and Clark	1	4%
Hispanic	2	9%	Missoula	4	17%
Other/Unknown	0	0%	Silver Bow	1	4%
	23	100%	Yellowstone	5	22%
			Out-of-State Diagnosis	3	13%
				23	100%

Source: Montana AIDS Program, MDHES, September 1988.

Note: There are two (2) other AIDS cases living in Montana which have been reported to MDHES. These were diagnosed and reported to Centers for Disease Control from other states. Those demographics are not included above.

As of September 30, 1988 there have been 167 positive HIV tests from 11,913 tests conducted through the DHES Public Health Laboratory.

MM/war-14xt

CAUSES OF NON-PREVENTABILITY IN THE
23 MEASLES CASES REPORTED JULY 1-SEPTEMBER 21, 1988
IN MONTANA

Classification	Non-Prev Cases (%)	Total Cases
Unknown Age	0 (0.00)	0
Person under 16 months of age	6 (26.09)	6
Born before 1957	2 (8.70)	2
16 months and over and born after 1956	15 (65.21)	15
	23 (100.0)	23

Person 16 Months - 28 Years			
A.	Adequately Vaccinated		0 (0.00)
	1. 12-14 months	0 (0.00)	
	2. On or after 15 months	0 (0.00)	
B.	International Import non-U.S. Citizen)		3 (20.00)
C.	Exemption		12 (80.00)
	1. Religious	0 (0.00)	
	2. Medical	0 (0.00)	
	3. Philosophical	12 (100.0)	
	4. Laboratory evidence of immunity	0 (0.00)	
	5. Documented evidence of prior measles	0 (0.00)	

DISCUSSION: The above chart demonstrates the non-preventability of this outbreak. NO IMMUNIZED CHILDREN BECAME MEASLES CASES.

Part 2 of the Measles Outbreak will be included in the October issue.

REP/vg-27d

MONTANA MEASLES OUTBREAK
(First part of a 2-part article)

A major measles outbreak occurred from 7/6 - 9/?1/88.

The initial case was a nine-year old who was not immunized for measles, was incubating measles upon arrival to Park County and attended an annual international conference where 3,000 to 3,500 people were then exposed to the disease.

There were 23 confirmed measles cases reported. Most cases (17) occurred in preschool ages. Two adults, both males, were also reported. Twelve of the measles cases live in Livingston, one in Gallatin County with the remainder living in communities south of Livingston along a 46 mile stretch between Livingston and Corwin Springs. Three of the cases were not U.S. citizens.

Exposure to the original case included people from 46 states. Approximately 1,170 people in Montana were identified as contacts to measles through the investigations.

All contacts were notified about the exposures, had their immunization status assessed, and were given recommendations for immunization and what to do if symptoms occur. To date, of those who were known "close" contacts, there were 18 who were found susceptible (over one year of age, born after 1956, no history of disease and not immunized) and were offered vaccine. Of those susceptible contacts, one was immunized and did not develop disease; 17 refused immunization; and two are not known if disease developed or not due to the parents unwillingness to let us know about their health status. For those susceptible contacts that refused immunization, 14 out of 15 developed disease. Nine of those children who developed disease and refused immunization were baby sat by the same person. It is suspected that they were intentionally exposed to the disease, as we know about four children who were brought to the house to be exposed.
REP/vg-29d

Volume: **Month of:**

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

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MONTANA MORBIDITY REPORT

Montana Epidemiology Report

Oct 1988

Montana State Department of Health and Environmental Sciences

STD NEWS

Guidelines for STD "Epidemiologic Treatment" and STD Treatment Guidelines Update

Epidemiologic treatment refers to antibiotic therapy given when a diagnosis is considered likely, based on clinical, laboratory or epidemiologic grounds but **before** results of confirmatory laboratory tests are known. The 1985 STD Treatment Guidelines of the Centers for Disease Control recommend it for **persons who are sexual contacts of confirmed cases of syphilis, gonorrhea or chlamydia.** The rationale for treatment includes the high rate of disease transmission for these diseases, the possibility of false negative results of laboratory tests, the frequent occurrence of complications from untreated infections and the minimal adverse reactions to antibiotic administration in the uninfected.

The risk of infection for a sexual contact has been estimated to be 10.1% for syphilis and 38.5% (males) to 65.1% (females) for gonorrhea. These estimates are taken from an article by Gavin Hart in the Journal of Sexually Transmitted Diseases, July-September 1980. Robert Johnson, in the Journal of Sexually Transmitted Diseases, April-June, 1979, suggests that approximately 70% of female sex partners of men with confirmed chlamydia also have chlamydial infections.

False negative results for GC culture on a female may be as high as 40% and 15% of women with untreated gonorrhea develop pelvic inflammatory disease. If treatment for a contact of gonorrhea is withheld pending culture results, a large number of persons may be falsely reassured that they have no disease and may then continue to spread the disease in the community. In addition to providing epidemiologic treatment, we recommend that confirmatory tests also be performed, in order to document infection and provide justification for partner notification of those patients.

The experience of some clinics is that patients named as contacts often do not keep return appointments for test results. They may be transient patients or leave false addresses.

The Division of Sexually Transmitted Diseases at CDC is planning to update (in early 1989) its STD Treatment Guidelines first published in 1985 and supplemented in September 1987 with policy guidelines for antibiotic-resistant strains of gonorrhea. If you have identified areas where the current document is unclear, out of date, or new areas that should be addressed, please send your recommendations to us by December 7, 1988, and we will forward them to CDC. If you want a copy of the 1985 STD Treatment Guidelines or the 1987 supplement on management of antibiotic resistant strains of GC, please write the MDHES STD Program, Cogswell Building, Room C-303, Helena, MT 59620.

References: Los Angeles County Public Health Letter, Vol. 10, No. 7, July, 1988.

MONTANA IMMUNIZATION PROGRAM

(Part 2 of Measles Outbreak
Continued from September Issue

The Park County Health Department offered measles vaccine at special clinics as did the Gallatin County Health Department.

The immunization status of school children in Park County is 99.2% for measles, with 17 children claiming measles exemptions. There were 51 doses of MMR given by the Park County Health Department during July compared to 12 doses in the previous month. Considering the good press coverage and advertisement of the clinic and the aggressive contact follow-up, there were few doses given. One of the reasons for relatively low use of the vaccine was that the people who needed to be vaccinated and were susceptible refused the vaccine. Two families chose to use red pills that were supposed to provide measles protection. After three children, who were on the pills had been exposed to a person with a rash illness, failed to develop measles after one week the parents told the county nurse (along with other friends) that the pills "worked." Unfortunately, one week later all of those children (including those on the pills) developed measles. The Immunization Program thinks that the use of red pills -- and the temporary assurance of parents that the pills worked -- helped support the philosophy that immunization is not the choice for the parents who failed to immunize their children.

Following the ACIP guideline to consider reimmunizing children previously immunized at 12-14 months of age, a record review took place of all public and private schools in Park County. 2,100 (100%) of the school records in the county were audited to identify exemptions and those to be considered for reimmunization. Letters were sent to parents informing them that if the outbreak was still on-going at the start of the 1988-89 school year their child may be excluded until the child is reimmunized (after 15 months) or immunized (for those with exemptions). During the week of August 22 there were about 200 children who received measles vaccine at two school clinics. According to the Park County nurse, approximately 180 of those were children who received vaccine before 15 months of age and the remainder had not previously been vaccinated. 15 children were among those who chose not to be immunized during the outbreak, had attended the international conference. It is interesting that the possibility of being kept out of school was more of a reason to be immunized, by some, than was the risk of measles.

NOTE: Suspected measles cases are to be reported by telephone immediately to the local health department and/or the Montana Immunization Program - 444-4740 (including nights and weekends). This should include any febrile rash illness. Prompt reporting is a key to preventing spread in your community.

Change in Labeling of
Oral Polio Vaccine

Effective October 1, 1988 there was a change in the use of the six digit "control number" printed on Lederle's packages and invoices for oral polio virus (OPV) vaccine. The Centers for Disease Control asked the drug manufacturer to begin using the lot number (0561F for example) on the invoices. This number also appears on Lederle's OPV packages and in a modified format on each vaccine dispette. Oral polio vaccine received from the Montana Immunization Program will have a label, describing this change, attached to the vaccine shipment receipt form.

Please note: The number found on the crimped end of each individual vaccine dispette is different. It is a modified version of the lot number (i.e., lot number 0561F will have dispettes numbered 561F1, 561F2, 561F3, etc.). Both versions of the lot number are acceptable for documenting vaccine receipt and administration.

Reporting of Adverse Event Following Immunization Update

The National Childhood Vaccine Injury Act: Requirements for Permanent Vaccine Records and For Reporting of Selected Events After Vaccination were published in the MMWR 1988; 37:198-200. This article was reproduced in JAMA (May 1988: Vol. 259; 2527-8). The same information has been published in the Federal Register and in the American Academy of Pediatrics News (June, 1988). The implementation of the National Vaccine Compensation Act requirements in March has caused some to wonder if the reporting systems presently used will continue. A single system for reporting or ultimately replacing the public vs. private reporting system is desirable.

However, for the foreseeable future, states will continue to report adverse events following administration of publicly purchased vaccines to CDC (through the Montana Immunization Program) while reports of adverse events following administration of privately purchased vaccine shall be reported by the person administering the vaccine to the FDA. The Report of Adverse Event Following Information, CDC 71.19 should be used for reporting events following public vaccine; the Adverse Reaction Report Form (FDA 16.39) should be used for events following private vaccine.

The Montana Immunization Program will keep all vaccine providers up-to-date on the current status of this issue.

CURRENT STATISTICS

MONTANA AIDS CASES
Demographic Summary as of 10/15/88

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RACIAL/ETHNIC GROUP			COUNTY OF DIAGNOSIS		
White	19	83%	Cascade	8	35%
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Hispanic	2	9%	Missoula	4	17%
Other/Unknown	0	0%	Silver Bow	1	4%
	23	100%	Yellowstone	5	22%
			Out-of-State Diagnosis	3	13%
				23	100%

Source: Montana AIDS Program, MDHES, October 1988.

Note: There are two (2) other AIDS cases living in Montana which have been reported to MDHES. These were diagnosed and reported to Centers for Disease Control from other states. Those demographics are not included above.

As of October 28, 1988 there have been 171 positive HIV tests from 12,252 tests conducted through the DHES Public Health Laboratory.

TREATMENT AND RESEARCH

Effect of Continuous Infusion of AZT in Children with HIV Infection

AZT helps children with symptomatic HIV infection, say Philip A. Pizzo and his colleagues, who studied the effects of continuous intravenous doses of the drug on 21 children aged 14 months to 12 years. Although some patients required blood transfusions to counter bone marrow suppression, there were no other signs of toxicity. All of the 13 children with encephalopathy, or neurodevelopmental abnormalities, showed improvement. The 13 patients, and 5 others without detectable evidence of encephalopathy, showed higher scores on IQ tests after three and six months of therapy. Most patients showed increased appetite and weight, and decreased hepatosplenomegaly and lymphadenopathy. Most also showed an increase in CD4 cells and decreased immunoglobulin levels. The researchers say the optimal intravenous dose of AZT is between 0.9 and 1.4 mg per kilometer of body weight per hour.
(New England Journal of Medicine, 10/6/88, Vol. 319, No. 14, p. 889.)

FDA Approves Tests of Imre Corp.'s Filter for AIDS Treatment

The Food and Drug Administration (FDA) has approved clinical testing of Imre Corp.'s Prosorba blood-filtration device as a treatment for people with AIDS, the company said. The 12-to-18 month tests, which the company hopes to begin this year, will determine if the device can remove HIV from the patient's blood. Prosorba filters the blood outside the body to remove immune-blocking factors. Patients taking part in the clinical studies will receive other treatments, but no anti-viral drugs. The device is already licensed to treat idiopathic thrombocytopenic purpura, or ITP, a blood-clotting disorder that often strikes AIDS patients. It has also shown promising results against Kapsoi's sarcoma, a cancer common to people with AIDS.
(Wall Street Journal, 10/11/88, p. 88.)

Sighting the AIDS Virus: Eyes Hold an Early Clue

The retina may be the first place to detect the onset of AIDS, according to University of California at San Diego researcher Dr. William R. Freeman. Freeman told a conference of the Research to Prevent Blindness organization in Arlington, VA, recently that noninfectious retinopathy or viral retinitis may show up in the majority of AIDS patients even before diagnosis is made. Retinopathy, also known as cotton wool spot, is a small white area doctors can detect with an ophthalmoscope. Viral retinitis infects the sides of the retina, often obstructing side vision. Cytomegalovirus, a virus many AIDS patients acquire, is often responsible for retinitis. Cotton wool spots do not cause blindness, but retinitis, if it goes untreated, can destroy vision. Retinopathy also shows up in patients with diabetes and high blood pressure, but Freeman says doctors should consider AIDS if those conditions are not present. Both AZT and ganciclovir, the drug used to treat retinitis, can cause anemia. Researchers are looking for ways to make the two drugs compatible.
(Washington Post (Health), 10/11/88, p. 11 (Dosa, Laszlo))

Blue Cross to Cover Aerosolized Pentamidine

Bowing to pressure from state officials and AIDS activists, Massachusetts Blue Cross/Blue Shield (BC/BS) on October 17 agreed to reimburse their clients for aerosolized pentamidine (AP), a drug that has had wide success in preventing and treating pneumocystis carinii pneumonia. The insurer is the largest in the state and the only one to cover AP, which costs about $165 per treatment. Michael Dukakis' AIDS advisor, John Dixon, said he acted as mediator between the insurer and the AIDS activists. A BC/BS spokesman said "new information" on the drug prompted the decision, not influence from Dukakis' office or pressure from AIDS groups. The FDA approved a liquid form of pentamidine several years ago, but it has yet to act on the more effective mist

treatment, which is inhaled directly to the lungs.
(Gay Community News, 10/23/88, Vol, 16, No. 15, P. 3 (Harris, Judy))

The AIDS Bill

The deletion of the confidentiality clause from the $1 billion AIDS testing, research, and education bill passed by Congress made the victory bittersweet for AIDS activists. Rep. Henry A. Waxman (D-Calif.), the bill's principal sponsor, said "the silence of the White House and the threats of a few senators" caused the omission. Sen. Jesse Helms (R-N.C.), who wanted it to be mandatory for physicians to inform the spouses of HIV carriers, succeeded in blocking the measure when he threatened a filibuster. However, the bill does call for anonymous testing, which may provide similar protection.
(Time, 10/24/88, Vol. 112, No. 17, p. 7 (Miller, Annetta))

Very Few Workers Exposed to AIDS Showed Infection

Only four of 1,200 health care workers exposed to HIV-infected blood subsequently tested positive for the virus, according to an ongoing Centers for Disease Control (CDC) survey. The agency began the survey in 1983 to track doctors, nurses and hospital workers who were accidentally exposed to the blood of people with AIDS under circumstances that would have allowed the blood to penetrate the workers' skin. Accidental hypodermic needle pricks made up 80 percent of the exposures, with another 8 percent involving cuts with sharp instruments. Seven percent involved exposure of open wounds on the workers to contaminated blood. Nurses suffered two-thirds of the accidental exposures, doctors 14 percent, and housekeeping and maintenance employees 2 percent. The rest were lab technicians and phlebotomists. All four workers who tested positive had suffered accidental needle pricks. According to the CDC, workers could have prevented 37 percent of the accidental exposures by following recommended safety procedures.
(Wall Street Journal, 10/26/88, p. 84 (Bishop, Jerry E.))

EDUCATION

San Francisco AIDS Foundation Kicks Off New AIDS Education Campaign

San Francisco -- A new AIDS education campaign directed at teens was announced by the San Francisco AIDS Foundation as it presented a comic book called "Risky Business." The book is designed to reach teens most at risk of infection from HIV-1, especially black teens.
(United Press International, 10/25/88)

AIDS Education Package for Workplace Unveiled

Nine corporations have announced the availability of a $190 kit to teach AIDS education to employees. The kit includes a video narrated by ABC medical editor Dr. Timothy Johnson in which three local workers with AIDS talk about the illness. The video attempts to encourage compassion for the infected and reduce fear among workers. The kit also provides a guide to the medical, legal, social, and financial impact of the disease and provides materials for establishing an in-house education program. The New England Consortium for AIDS Education produced the packet, which is entitled "AIDS in the Workplace: Taking Care of Business."
(United Press International, 10/26/88)

CONFERENCES

The Fourth Annual Rocky Mountain Conference on AIDS will be held January 27 and 28, 1989 at the Radisson Hotel in Denver. Conference registration is $95; early registration by December 15 is $75. For more information contact Peter Ralin at (303) 893-6300 or Ann Shields at (303) 837-0166.

OCTOBER 1988	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		1													
Big Horn		6				1					2	4	1	10	
Blaine		2										1			
Broadwater															
Carbon													1		
Carter												1			
Cascade		16	2	7			2				4	1			
Chouteau															
Custer												1			
Daniels												1			
Dawson												1			
Deer Lodge		4	1												
Fallon															
Fergus		1	1									2			
Flathead	2	5										1			
Gallatin	4	21	5										1		
Garfield											4	1			
Glacier		3												15	
Golden Valley												1			
Granite															
Hill		2	2			3	1					1			
Jefferson															
Judith Basin												1			
Lake		1													
Lewis & Clark		12											3		
Liberty													1		
Lincoln		4													
McCone															
Madison	1														
Meagher															
Mineral															
Missoula	1	16	3	2											
Musselshell													1		
Park															
Petroleum															
Phillips															
Pondera															
Powder River															
Powell															
Prairie															
Ravalli		5				1									
Richland					1										
Roosevelt		8		6									1	1	
Rosebud		3		2											3
Sanders															1
Sheridan															
Silver Bow		3				1					1		1		
Stillwater															
Sweet Grass															
Teton															
Toole															
Treasure															
Valley															
Wheatland															
Wibaux															
Yellowstone	1	20	3	7								1		1	
MONTHLY TOTAL 1988	9	133	17	26	1	6	3	0	0	0	11	18	10	27	4
MONTHLY TOTAL 1987	4	190	24	54	5	9	5	0	0	0	24	10	9	4	2
MONTHLY TOTAL 1986	4	89	34	50	2	9	6	3	1	2	7	12	9	4	2
TOTAL TO DATE 1988	71	1634	184	342	9	36	46	10	4	1	82	190	85	188	19
TOTAL TO DATE 1987	33	1146	135	514	17	80	46	9	3	4	108	105	68	27	12
TOTAL TO DATE 1986	57	521	185	598	22	72	47	9	9	10	109	181	44	16	25

OTHER DISEASES: Aseptic Meningitis: Roosevelt, 1; Bacterial Meningitis: Missoula, 1; Valley, 1; Chickenpox: Dawson,1; Yellowstone, 13; Hib Invasive Disease: Dawson, 1; Legionellosis: Cascade, 1; Measles, Imported: Flathead, 9; Park, 2

DELAYED REPORTS:
September: Delete 1 case Lyme Disease from Silver Bow

Shigellosis

To date, there have been 188 cases of Shigellosis reported to MDHES for 1988. This compares to a total of 42 cases reported in all of 1987. The 42 cases in 1987 were reported from 15 counties while the 188 cases this year have been reported from only 12 counties. There has been a concentration of cases in four counties and they are as follows: Big Horn County - 121 cases; Glacier County- 24 cases; Rosebud County - 21 cases; and Yellowstone County - 7 cases. The reported number of cases so far this year is 4-1/2 times as many as the number of cases reported for all of 1987.

There have been several large outbreaks of Shigellosis reported nationally. In 1987, an outbreak beginning with the annual Rainbow Family gathering in North Carolina spread throughout the United States when participants from the gathering returned to their respective homes. In the summer of 1988, Shigellosis occurred in epidemic proportions at the Michigan Women's Music Festival. The festival was held near Hart, Michigan, August 10th through 14th. There were 7,500 attendees from all states in the U.S. except Utah and South Dakota and several foreign countries. The attendees camped at the site. The attack rate may have been as high as 10%. Montana has not documented any cases being connected with the Michigan Women's Music Festival.

Within the last few months, an outbreak of Shigellosis linked to Northwest Orient airline has been reported. Northwest Orient's headquarters are located in Minneapolis and the outbreak has been investigated by the Minnesota Health Department. MDHES has not linked any of the cases reported to travel aboard Northwest Orient airlines.

Shigellosis is an acute disease with symptoms of diahrrea, fever, nausea, vomiting, cramps and tenesmus. Stools are often bloody and/or contain mucus and pus. Illness is usually self-limited lasting several days to weeks with an average of 4-7 days. The disease's severity is dependent upon the age and general nutrition status of the host as well as the infecting dose. Most infections with Shigella sonnei result in a short course and a low fatality rate. The cases reported to date to MDHES have been mostly Shigella sonnei.

The mode of transmission of Shigella is direct or indirect fecal-oral transmission from a patient or carrier. Infection may occur after the ingestion of very few organisms. Therefore, in communities where Shigella is occurring, scrupulous handwashing after defecation is essential. Food servers and persons employed in other sensitive occupations must employ good hygiene. In the communities experiencing increased Shigellosis in Montana, community education has been done to increase the population's awareness of the need for good hygiene. Presentations have been done by nurses and health educators to community groups, schools, and day cares. Although water or contaminated food sources are often considered as a primary vehicle for transmission, the most likely vehicle is the contaminated hands of an infected person.

Whenever feasible, ill contacts of Shigellosis patients should be excluded from food handling and other sensitive occupations such as caring for children or institutionalized patients until they have two successive negative stool cultures. Cultures of contacts should be confined to food handlers or people in other sensitive occupations where the spread of infection is particularly likely.

The specific treatment for Shigellosis includes fluid and electrolyte replacement and antibiotic treatment. It will shorten the duration of illness, and may be given to contacts who care for children or other persons at greatest risk. However, multi-resistance to antibiotics is common and agents should be prescribed only after susceptibility patterns are known.

Information for International Travelers

The Montana Department of Health and Environmental Sciences receives yearly information from the Centers for Disease Control concerning the immunization requirements and health suggestions for international travelers. The information contained in the book from Centers for Disease Control is updated via bulletins weekly and as needed for situations arising between publications of the book. We recently received an advisory memorandum from the Division of Quarantine, Center for Prevention Services, Centers for Disease Control concerning poliomyelitis in Israel. The text of that advisory memorandum is as follows: "Between July 31 and September 28, 1988, sixteen persons in Israel were reported with onset of confirmed or suspected paralytic poliomyelitis. Thirteen cases were reported from the sub-district of Hadera located approximately 30 miles northeast of Tel Aviv. To date, type 1 polio virus has been isolated from eight persons. Vaccination of all persons through age 39 years was carried out in Hadera and is in progress in the other 14 sub-districts. Epidemiological investigation is continuing.

Proof of poliomyelitis immunization is not required for international travel. However, the Immunization Practices Advisory Committee (ACIP) recommends that travelers to countries where poliomyelitis is occurring -- which now temporarily includes Israel -- be immunized. Schedules for primary immunization against poliomyelitis requires three or more doses. In general, oral polio virus vaccine (OPV) is the vaccine of choice for persons younger than 18 years of age. Unimmunized adults (18 years and older) should receive at least two doses of enhanced potency inactivated polio virus vaccine (eIPV), at least four weeks apart, and preferably a complete primary series, before traveling. If an individual's travel plans do not permit this interval, then a single dose of OPV or eIPV is recommended. For adults incompletely immunized with OPV or IPV, the remaining doses should be given to complete the primary series, regardless of the interval since the last dose or the type of vaccine previously received; either OPV or eIPV can be used to complete the series. A single additional dose of either OPV or eIPV should be given to travelers of all ages who completed a primary series of OPV or IPV. ACIP recommendations on poliomyelitis prevention should be consulted for further details."

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Montana Epidemiology Report

MONTANA MORBIDITY REPORT

Nov 1988

Montana State Department of Health and Environmental Sciences

FIFTH DISEASE -- HUMAN PARVOVIRUS AND PREGNANCY

Erythema infectiosum, commonly known as fifth disease, was first described 100 years ago. It was so named because it was considered the fifth known rash illness, the first four being scarlet fever, rubeola, rubella, and epidemic pseudo-scarlatina. Human parvovirus B19 (B-19) was isolated in 1975 and was subsequently implicated as the causative agent of fifth disease in 1983. The entire spectrum of B-19 infection is still being defined. B-19 infection was associated with aplastic crisis in patients with hemolytic anemia in 1981, with stillbirths in 1984, and with acute arthritis in 1985. The association of B-19 infection with fifth disease and aplastic crisis is well supported by numerous studies. The importance of B-19 infection as a cause of stillbirths and arthritis is not as clear. This article will focus on the occurrence of fifth disease in children and the risk posed by exposure to the infection to pregnant women.

Epidemiology

The age-specific attack rate of fifth disease parallels the prevalence of immunity to the virus. The level of immunity in children less than 5 years old is from 2 to 9% and increases to 30 to 60% among adults. The highest attack rate of fifth disease occurs in school-aged children who experience a low level of immunity along with a high level of exposure to the infection.

Studies of secondary illness in households have provided information on the incubation period, the rate of asymptomatic infection, and the risk of infection after exposure to the virus in a household setting. From these studies the incubation period for fifth disease is between 4 to 14 days but can be as long as 20 days, and the secondary attack rate is estimated at 50 to 60% among susceptible persons (persons B-19 IgG negative). Approximately 50% of household contacts with B-19 infection are not recognized due to the sub-clinical nature of their infection.

Outbreaks of fifth disease in a school setting are common. Usually these outbreaks begin in mid- to late winter but can occur at any time of the year. Outbreaks beginning in mid-winter frequently last until the end of the school year with 2 to 6 months duration. Fifth disease seems to occur cyclically, with peaks in incidence occurring every 5 to 7 years.

B-19 is a species specific virus with man being the only known host. Studies suggest that person-to-person transmission occurs by exposure to infectious respiratory secretions. In persons with B-19 infection, respiratory secretions are believed to be infectious approximately 5 days before onset of illness and, to a lesser degree, 2 days after. There may also be a short period of viremia.

Clinical Manifestations

Most commonly fifth disease occurs in school-age children in three characteristic stages. Stage one involves an intensely red facial rash, giving the

distinctive "slapped cheek" appearance. After one to four days, a symmetrical maculopapular rash appears on the arms, moving to involve the trunk, buttocks and thighs. In the third stage, which lasts one to three weeks, the rash recurs and fluctuates in intensity with exposure to environmental stimuli such as extremes of temperature, sunlight and emotional stress. Up to 60% of patients have a prodromal phase manifested by fever, malaise, myalgias, upper respiratory symptoms or gastro-intestinal symptoms. This prodromal phase lasts from 1 to 4 days. In adults, arthralgias and arthritis may occur in addition to the more typical symptoms described above.

B-19 Infection and Pregnancy

Of more prominent concern is evidence associating HPV B-19 with risk of fetal death. Since 1984 numerous reports in the literature have linked B-19 infection with fetal deaths. However, most of the over 170 cases of B-19 infection during pregnancy reported in the literature have led to no abnormalities in the infant. There is no evidence to link congenital abnormalities with B-19 infection.

It is hypothesized that fetal death subsequent to maternal B-19 infection results from a mechanism similar to the pathogenesis of aplastic crisis. B-19 selectively infects red blood cell precursors and shuts down red blood cell production. The result is shortened cell survival and expanding cell volume leading to severe anemia. The severe anemia is followed by congestive heart failure, generalized edema, and death. The preceding pathologic scenario is consistent with nonimmune hydrops fetalis.

Current understanding is that only B-19 IgG antibody negative women are at risk of fetal loss due to maternal B-19 infection. As mentioned previously, serologic studies show that in the United States the adult population has a B-19 IgG antibody positivity rate of 30-60 percent. In addition, the risk of fetal loss due to B-19 infection, seems to be greatest in the first half of the pregnancy.

Mothers of school-age children and teachers are at particular risk of exposure to B-19 infection. Because of the close, intimate contact that occurs among members of the same household, the secondary attack rate is quite high, at about 50% of susceptible women. In a school setting, contact is not as close and hence not as effective at transmitting the infection. The secondary attack rate has been estimated to be about 15%. Available data is very limited but suggests that the risk of fetal death to a woman with B-19 infection in the first half of pregnancy is probably less than 5%. When this risk estimate is combined with the secondary attack rate of 50% in a household it may be assumed that a susceptible woman in the first half of pregnancy has an estimated 2.5% risk of fetal death f exposed to B-19 infection by a household contact, while the risk to a susceptible school teacher in the first half of pregnancy exposed to B-19 by contact with an infectious student is less than 1%. These figures may appear to be exact, but are in fact based on very limited data and so should be considered only rough estimates at best. It is really not known with confidence the extent of risk a pregnant woman faces in different settings at this time.

Prevention

When considering an exposure situation, it is important to remember that the period of greatest infectivity precedes the development of the rash. Preventing additional household exposure at home is difficult, but prevention of further exposure in a school setting may be possible. Formal approaches to the management of pregnant, susceptible women with continuing exposure to B-19, such as a teacher in a school where a fifth disease outbreak is occurring, must be based on estimations of risk and consideration of options by the pregnant woman and her physician in consultation with public health officials. It may be helpful to determine the antibody status of the exposed pregnant woman. However, the resources to provide antibody testing are not readily available.

Further study is underway to determine the rate of infection after different types of exposure and ways to prevent and treat congenital B-19 infections. The Centers for Disease Control will host a symposium

of experts in the area of congenital infections to discuss management options and strategies in late October 1988. Additional data from well designed and implemented studies will be essential to the development of appropriate management options. Due to the inconclusive nature of studies done so far, each exposure situation needs to be considered separately. If an exposure situation comes to your attention, the Montana Department of Health and Environmental Sciences Communicable Disease Section can be contacted for consultation at 444-4740.

Prepared by Kathy Kringle, M.P.H., Epidemiologist with the General Communicable Diseases Division, OSDH.

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RESEARCH

Research Funds Announced

The National Center for Health Services Research and Health Care Technology Assessment (NCHSR) has been asked to investigate ways to add to existing knowledge on health services issues in HIV-related illness. NCHSR is interested in the study of health services research issues on the availability, cost and utilization of services for different HIV risk groups, population areas, stages of illness, and treatment modalities. Other topics including the financing of services for AIDS and the effects of disease on the organization and management of health care services.

MDHES has received a brochure outlining researchable topics and describing application procedures. To request a copy of the brochure, contact the MDHES AIDS Program and ask for the Health Services Research Brochure.

NIAID Extends AIDS Research

The National Institute of Allergy and Infectious Diseases (NIAID) has $6 million budgeted to launch the Community Programs for Clinical Research on AIDS. NIAID hopes the program will draw community physicians and their patients into the battle on AIDS. In the program, the agency will trade researchers, statisticians, and computer services for data it is not now receiving. NIAID Director Anthony S. Fauci said the program should also make experimental drugs available to people who could not previously enter trials because they had taken unauthorized treatments or were too sick. As well as "including primary care physicians who are not affiliated with AIDS research efforts that are currently supported by NIAID," Fauci said he hoped the program would reach minorities, at-risk women, and IV drug users. Gay males have been the primary participants among the 5,000 who have taken part in government-sponsored research. Currently, 15 patients are turned away for every one accepted into government trials.

From Washington Post, (Health) (11/22/88)

A Six-Year Follow-up of HIV Infected Homosexual Men with Lymphadenopathy

In a follow-up of 75 HIV-positive homosexual men with generalized lymphadenopathy that began in Atlanta in 1982 and 1983, 22, or 29 percent, had developed AIDS by November 30, 1987. Two cases developed in each of the first three years following the onset of lymphadenopathy. Years four, five, and six showed six, seven, and three new cases respectively. The men showed a six-year cumulative incidence of AIDS of 38 percent. Those men with lower T-helper cell counts were much more likely to develop AIDS. The researchers comment that this study suggests there is a much greater risk of developing AIDS after three years -- other studies have suggested only a continuing risk. However, the researchers do not know the exact times of infection, so they cannot predict whether the incidence of AIDS has peaked in this group. The study backs up others that have indicated that a precipitous loss of T-helper cells is a precursor to the onset of AIDS. Research has yet to discover what triggers the decline of the cells, however.

From Journal of the American Medical Association (11/11/88), Vol. 260, No. 18, p. 2694

Saliva Inhibits HIV Infectivity

Saliva infects HIV infectivity, according to a preliminary study by Philip Fox, DDS, and colleagues at the National Institute of Dental Research. The researchers incubated HIV-1 in growth medium with whole saliva samples and samples of individually collected submandibular and parotid gland secretions from three healthy adult males. Eight days after the suspension of phytohemagglutin-activated normal human peripheral blood lymphocytes in each sample and the release of HIV-1, the saliva had completely inhibited the ability of the virus to infect the lymphocytes. The submandibular gland secretions showed the same ability. The results of further experiments suggest that the inhibitory activity may be related to a macromolecular component of saliva, and not pH, ionic concentration, or some other specific factor. Research is continuing to identify the inhibiting component and to clarify this oral defense mechanism.

From Journal of the American Medical Association, (11/18/88), Vol. 260, No. 19, p. 2791.

Penicillinase-Producing Neisseria gonorrhoeae in Montana

December 5, 1988 a case of penicillinase-producing neisseria gonorrhoeae (PPNG) was diagnosed in Yellowstone County. This is the second case of PPNG reported in Montana in 1988.

In 1986, penicillinase-producing neisseria gonorrhoeae (PPNG) infections accounted for approximately 2% of gonorrhea reported in the United States, a 90% increase over the 1985 percentage. The majority of PPNG cases were reported in Florida, New York, and California.

Specimens from patients expected to have gonorrhea should be tested to determine whether or not they are sensitive to penicillin. This testing is routinely done at the Montana State Department of Health and Environmental Sciences' Microbiology Laboratory.

Patients with proven PPNG infection or who are likely to have acquired gonorrhea in areas of high PPNG prevalence and their sex partners should receive spectinomycin 2.0 g IM, or ceftriaxone 250 mg IM, both followed by tetracycline or doxycycline, or erythromycin. To treat pharyngeal gonococcal infection due to PPNG: ceftriaxone 250 mg IM, or 9 tablets of trimethoprin/sulfamethoxazole (720 mg per 3600 mg) per day in one daily dose for five days. Patients who fail standard treatment for gonorrhea or who have infection with penicillin-resistant strains that do not produce betalactamase (CMRNG) should be treated with spectinomycin 2.0 g IM or ceftriaxone 250 mg IM.

As is recommended for all gonorrhea patients, patients treated for PPNG should have a test of cure done 7-10 days after completion of treatment. Persons having questions about penicillin-resistant gonorrhea cases should contact the Sexually Transmitted Disease Program at the Montana Department of Health and Environmental Sciences by calling 444-4740. The program wishes to know about confirmed or suspected PPNG cases as soon as possible so complete contact investigations can be carried out. It is the

DIAGNOSING AND TREATING SYPHILIS IN HIV-INFECTED PATIENTS

The clinical manifestations, serologic responses, efficacy of treatment, and occurrence of complications of syphilis may be altered in patients coinfected with human immunodeficiency virus (HIV). Because syphilis is a disease with a broad range of manifestations and variable course, assessing reports of unusual clinical or laboratory findings in HIV-coinfected patients is difficult. However, in some HIV-infected patients with biopsy-confirmed secondary syphilis, both nontreponemal and treponemal tests for syphilis are negative. The frequency of unusual clinical and laboratory manifestations of syphilis in patients coinfected with HIV is unknown.

The recommendations offered are:

1. Persons with HIV infection acquired through sexual contact or intravenous (IV) drug abuse should be tested for syphilis, and all sexually active persons with syphilis should be tested for HIV (with the informed consent of the patient).

2. When clinical findings suggest syphilis is present, but serologic tests are negative, other tests should be used to determine if syphilis is present.

3. Laboratories should titrate nontreponemal tests to find a final endpoint.

4. Neurosyphilis should be considered in the differential diagnosis of neurologic disease in HIV-infected persons.

5. Consultation should be obtained to evaluate unusual serologic test results in patients suspected of having syphilis or in those being followed for response to treatment.

6. Case reports have suggested that treatment failures, including progression to neurosyphilis, may occur more frequently in patients coinfected with HIV than in those with syphilis alone.

7. No change in therapy for early syphilis for HIV-coinfected patients is recommended.

8. Serologic testing after treatment for early syphilis is important for all patients, regardless of HIV infection status.

9. A CSF examination should precede and guide treatment of HIV-infected patients with latent syphilis present for longer than 1 year or for unknown duration. If an examination is not possible, patients should be treated for presumed neurosyphilis.

10. Benzathine penicillin regimens should not be used to treat either asymptomatic or symptomatic neurosyphilis in HIV-infected patients.

So that the frequency of unusual manifestations of syphilis can be determined, health care providers are requested to notify their state epidemiologists of HIV-infected patients who meet one of the following conditions:

1. Neurosyphilis confirmed by CSF examination or histopathology;

2. Negative serologic tests for syphilis (nontreponemal [VDRL, RPR] or treponemal [FTA-ABS, MHA-TP, HATTS] tests) during secondary syphilis diagnosed by darkfield microscopy or histopathology of lesion material.

The state epidemiologist will forward these reports without personal identifiers to the Division of Sexually Transmitted Diseases, Center for Prevention Services, CDC.

Excerpted from October 7,1988, MMWR.

LOST

The AIDS Program's copy of And The Band Played On has disappeared! Someone borrowed it this summer, but we have no record of who it was. If you have our copy of this important (and expensive to replace) book, please return it to us, or let us know where it is, so that we can eventually reclaim it!

Misleading AIDS Claims for Typhoid Vaccine

An FDA official has issued a statement in response to a recent article in SPIN magazine which claimed that the FDA had approved the use of the typhoid vaccine as a treatment for AIDS. FDA has not approved the use of the typhoid vaccine as a treatment for AIDS, nor is the agency aware of any scientific evidence that would suggest that the vaccine is effective for this indication. Typhoid vaccine's only approved purpose is to prevent typhoid fever -- a severe bacterial disease. To date those individuals cited in the SPIN magazine article as having received permission to market typhoid vaccine to treat AIDS, have never even applied to the agency for permission to test the vaccine in AIDS patients. State laws permit licensed physicians to use approved therapies and vaccines to treat individual patients for conditions other than those for which the product is labeled. However, FDA cautions that patients with AIDS should consider that no scientific evidence is available to show that the use of the typhoid vaccine will be helpful in treating the disease or slowing its progression.

Flathead County Measles Outbreak Update

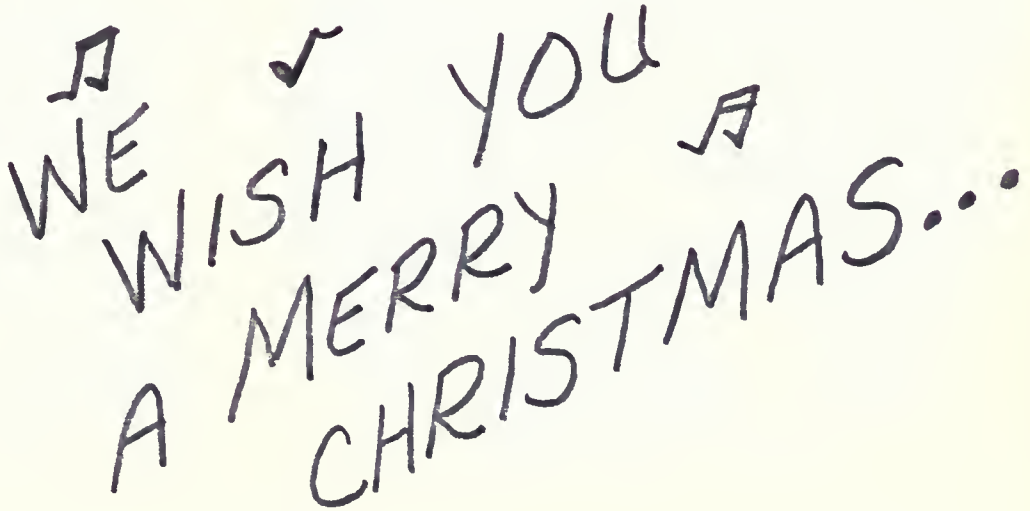
As of December 5, 1988 there have been 33 cases of measles (rubeola, 7-day, hard) reported in Flathead County with 22 cases reported since November 23. Most of the cases have been reported in Flathead County High School, although cases have been reported in college, elementary and junior high school students. The Flathead County health officer has recommended that no one travel into the Kalispell area unless they are immunized.

Measles vaccine is recommended for all persons 15 months of age or older unless:

1. They were born in 1956 or earlier, or
2. have had physician diagnosed measles disease.

Persons who received measles vaccine between 1963 and 1967 should be re-vaccinated unless they received live-virus measles vaccine. Also, persons who were vaccinated earlier than 15 months of age and who are planning to travel to the Kalispell area should be re-vaccinated. Infants less than 15 months of age are not routinely immunized against measles and should not travel into areas where measles may occur.

Suspected measles cases should be reported immediately, by phone, to the county health department and/or the Montana Immunization Program at 444-4740.



NOVEMBER 1988	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2													
Big Horn		6		1								2			1
Blaine		2		1											
Broadwater															
Carbon											1	3			
Carter															
Cascade		20		8	1		2				1	3		2	5
Chouteau															
Custer		2													
Daniels															
Dawson		1													
Deer Lodge		1		1											
Fallon						1									
Fergus												1			
Flathead		4		2			1						1		
Gallatin	3	20	1	1											
Garfield															
Glacier		9		6										18	
Golden Valley															
Granite															
Hill															
Jefferson															
Judith Basin															
Lake		4		1											1
Lewis & Clark		13		3									1	1	
Liberty															
Lincoln		4	1												
McCone												1			
Madison															
Meagher															
Mineral		1													
Missoula	1	17	3				2						1		1
Musselshell		2													
Park		2	1												
Petroleum															
Phillips															
Pondera				1										1	
Powder River															
Powell															
Prairie							1								
Ravalli															
Richland															
Roosevelt		8		7										2	1
Rosebud		4									2	2			
Sanders		1		1											
Sheridan															
Silver Bow	2	4					1								
Stillwater															
Sweet Grass															
Teton						1									
Toole															
Treasure															
Valley		1													
Wheatland															
Wibaux															
Yellowstone	2	20	1	3		1							1		3
MONTHLY TOTAL 19 88	8	50	7	36	1	3	7	0	0	0	4	12	4	24	12
MONTHLY TOTAL 19 87	2	N/A	17	44	1	6	4	0	0	0	8	20	3	1	4
MONTHLY TOTAL 19 86	4	68	24	41	3	3	2	1	1	0	5	10	7	7	0
TOTAL TO DATE 19 88	79	1784	191	378	10	39	53	10	4	1	86	102	89	212	31
TOTAL TO DATE 19 87	35	N/A	152	558	18	86	50	9	3	4	116	125	71	28	15
TOTAL TO DATE 19 86	61	589	209	639	25	75	49	10	10	10	114	191	51	23	27

OTHER DISEASES: * Chlamydia numbers for November, 1987 will be added to December, 1987 numbers.

Chickenpox: Cascade, 2; Stillwater, 2; Yellowstone, 1

Measles, Indigenous: Flathead, 1

Measles, Imported: Flathead, 3

Yersiniosis: Missoula, 1

CURRENT STATISTICS

MONTANA AIDS CASES
Demographic Summary as of 10/15/88

CASES			SEX		
Reported Cases	23	100%	Female	3	13%
Reported Deaths	13	57%	Male	20	87%
				23	100%
AGE			RISK FACTOR		
Less than 5	0	0%	Homosexual/Bisexual Male	12	52%
5-12	0	0%	IV Drug Abuser	3	13%
13-19	0	0%	Homosexual Male & IVDA	2	9%
20-29	6	26%	Hemophilia, etc.	2	9%
30-39	12	52%	Heterosexual	3	13%
40-49	4	17%	Transfusion, Blood Components	0	0%
Over 49	1	4%	Undetermined*	1	4%
	23	100%		23	100%
RACIAL/ETHNIC GROUP			COUNTY OF DIAGNOSIS		
White	19	83%	Cascade	8	35%
American Indian	1	4%	Gallatin	1	4%
Black	1	4%	Lewis and Clark	1	4%
Hispanic	2	9%	Missoula	4	17%
Other/Unknown	0	0%	Silver Bow	1	4%
	23	100%	Yellowstone	5	22%
			Out-of-State Diagnosis	3	13%
				23	100%

Source: Montana AIDS Program, MDHES, November 1988.

Note: There are seven (7) other AIDS cases living in Montana which have been reported to MDHES. These were diagnosed and reported to Centers for Disease Control from other states. Those demographics are not included above.

As of November 18, 1988 there have been 171 positive HIV tests from 12,513 tests conducted through the DHES Public Health Laboratory.

* Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed, or loss to follow-up, and patients still under investigation).

Volume: 12:12 **Month of:** NOVEMBER, 1988

MONTANA MORBIDITY REPORT. Pub. No. 397830. Published monthly with an extra issue for March by the Health Services Division of the Department of Health and Environmental Sciences, Cogswell Building, Helena, MT 59620. (406) 444-4740.

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Montana Morbidity Report

Volume: 12:13 Month of: December, 1988

Montana State Department of Health and Environmental Sciences

Measles Update in Montana as of 1/11/89

There have been 72 cases of measles reported in Flathead County since the start of the outbreak. Six suspected cases of measles have been reported in Butte, one of which has been confirmed by laboratory testing. The last rash onset for Flathead County was 12/30/88 and the last rash onset for a Butte case was 12/21/88. Measles outbreaks are considered as "over" if there have been no cases within a 4-week (2 generation) time period. Upon completion of the outbreaks there will be a measles report developed and available for distribution. A breakdown of case generation (Gen.) for Flathead County is as follows:

Gen. #	Gen. Dates	# of Cases
Index Case	9/29 (Rash onset)	1
1st	10/5-10/18	5
2nd	10/19-11/1	4
3rd	11/2-11/15	2
4th	11/16-11/29	18
5th	11/30-12/13	30
6th	12/14-12/27	10
7th	12/28-1/10/89	2

It is interesting to note that the majority of the cases occurred in junior high and high school students and that, By October 31, there were no students attending Flathead County High School who had not been immunized after 15 months of age. The continuation of the outbreak in the fourth, fifth and sixth generation played an important part in the Department's decision to implement the new CDC recommendation to immunize persons in outbreak areas that had been immunized prior to 1980. To date that approach appears to have been effective for the Butte outbreak.

Pertussis in Yellowstone County and Recent Outbreak in Idaho

Two pertussis cases were reported in Yellowstone County during December. The cases occurred in infants who were siblings. Montana has not experienced any major pertussis outbreaks in 1988 however, there were more than 370 confirmed pertussis cases reported in Idaho during 1988, primarily in the southwestern region. According to the Idaho Immunization Program, the actual number of cases was probably considerably higher than those that were confirmed. More than 25% of the Idaho cases occurred in older children and adults (including one person 68 years of age). All infected people can be a vehicle to transmit the disease to infants who suffer the most serious consequences of the disease.

The Department recommends there be a special effort to ensure pertussis vaccination occurs on schedule in all persons less than seven years old. The Montana Public Health Laboratory provides routine screening for suspect pertussis cases and should be consulted prior to submitting samples to insure proper collection and transportation takes place. The Administrative Rules of Montana, related to laboratory testing, includes pertussis as one of the diseases that requires confirmation by the Department's Public Health Laboratory.

HUMAN RABIES PREVENTION

The epidemiology of animal rabies in Montana has changed. Until the late 1970s there was an imaginery line extending from Kalispell to Billings. To the west of the line is was assumed animals other than bats would not be rabid. But since the end of the 70s this can no longer be assumed. Rabies cases in animals have occurred in 38 counties in Montana during the past year. Counties in the "western" counties reporting other than bat rabies cases include Beaverhead, Flathead, Carbon, Gallatin, Lake, Lewis and Clark, Powell and Sanders. Every county has reported bat rabies at some point in time. The total number of animals tested positive for rabies in Montana in 1987 was 187. Only nine other states than Montana had more animals testing positive for rabies in 1987.

When a person in Montana has saliva-mucous membrane contact with any wild or stray domestic animal the possibility of the animal being rabid must be considered. Although the likelihood of an owned domestic animal being rabid is less it must also be considered. Those domestic animals which have been outside, unsupervised by a human must be considered to have had the opportunity to have come in contact with a wild rabid animal. Montana has an average of 7 rabid domestic animals per year.

Wild animals and stray domestic animals biting or exposing a human in such a way rabies virus could have been transmitted should be immediately sacraficed and submitted to the Department of Livestock Diagnostic Laboratory in Bozeman. Veterinarians and rabies control agents have specific information regarding the correct procedures for doing this.

Persons exposed by bite or mucous membrane contact to saliva of a known rabid animal should receive anti-rabies biologicals. Persons exposed to a wild animal which was not captured will probably need to have the post-exposure rabies treatment. Those exposed to captured wild or stray animals can wait to start treatment until the testing of the animal is complete since it can be done very rapidly. There may be instances where behavior of the animal indicative of rabies and/or circumstances of the exposure warrant starting the post-exposure rabies treatment before testing of the animal is completed. The series is discontinued if the animal tests negative. Exposure to a domestic animal not likely to be rabid can be deferred while the animal is observed for 10 days. At any sign of illness the animal should be euthanized and tested and the person started on post-exposure rabies treatment if the testing of the animal cannot be immediate and/or the exposure ie., a face bite, warrants it.

MDHES Communicable Disease Section personnel are available for consultation about possible need for rabies post-exposure treatment. An answering service is maintained for this consultation to be available to local health care providers 24 hours a day, 7 days a week. Consultation about rabies post-exposure prophylaxis can be had by calling 406 444 4740 and asking to speak to someone about rabies.

Timeliness is important in preventing human rabies after an exposure to a rabid animal. It is important to begin the appropriate treatment as soon as it is known it is needed.

See Figure 1 page 3

Hepatitis B Vaccine and Immune Globulin Term Contract (January 1, 1989 - December 31, 1989)

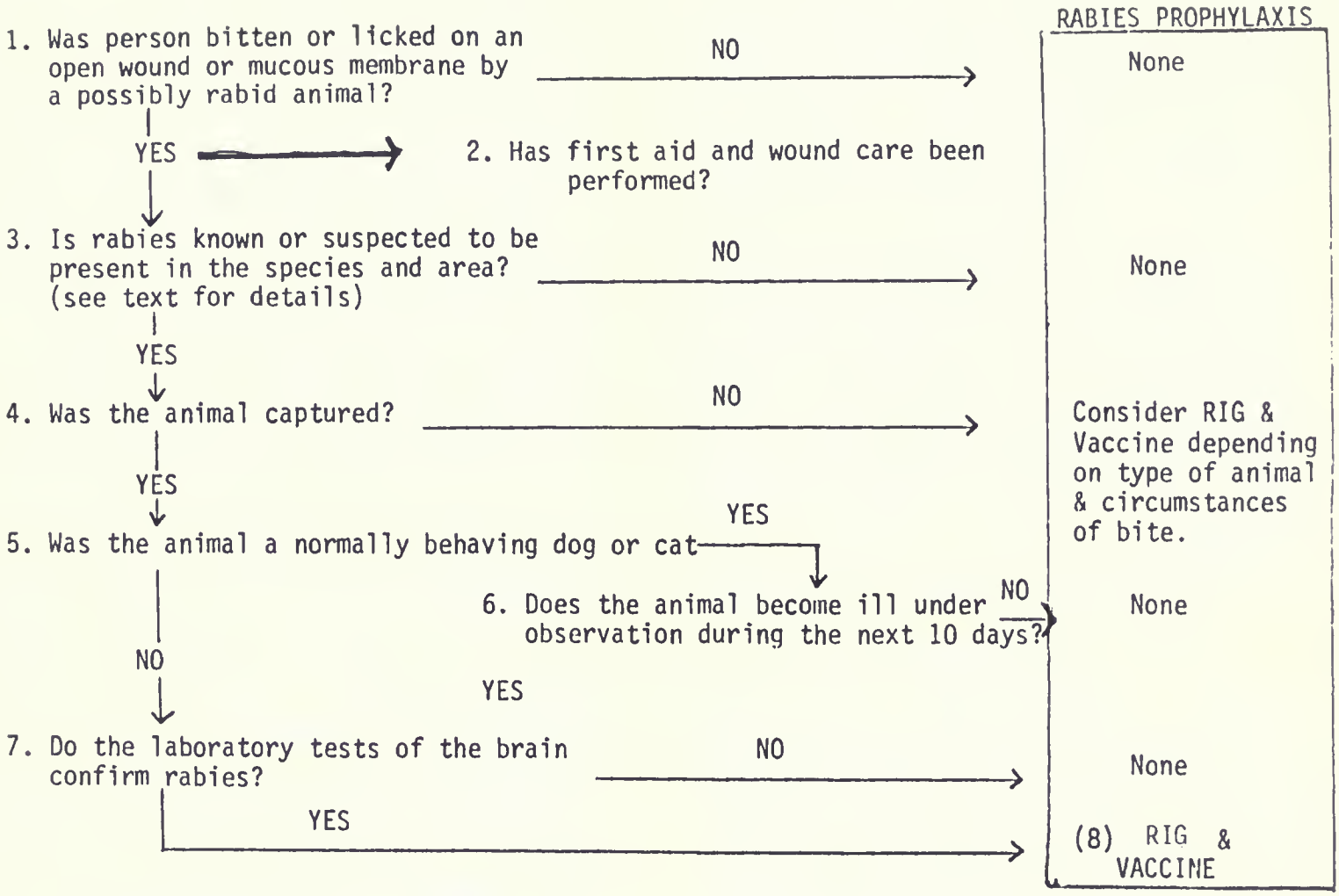
The state contract for purchase of Hepatitis B vaccine and immune globulin has been renewed through the Department of Administration for use by public agencies. For information and conditions for use of the term contract contact the Montana Immunization Program at 444-4740.

The following is a summary of vaccine costs:

Hepatitis B Vaccine Type	Cost/ Vial
Adult, 3 ml vial	$136.40
Pediatric, 1 dose vial	36.40
Immune Globulin, 5 ml vial	257.59

FIGURE 1

ALGORITHIM FOR RABIES PROPHYLAXIS


RABIES PROPHYLAXIS
1. Was person bitten or licked on an open wound or mucous membrane by a possibly rabid animal?
NO
None
YES
2. Has first aid and wound care been performed?
3. Is rabies known or suspected to be present in the species and area? (see text for details)
NO
None
YES
4. Was the animal captured?
NO
Consider RIG & Vaccine depending on type of animal & circumstances of bite.
YES
5. Was the animal a normally behaving dog or cat
YES
6. Does the animal become ill under observation during the next 10 days?
NO
None
NO
YES
7. Do the laboratory tests of the brain confirm rabies?
NO
None
YES
(8) RIG & VACCINE

Influenza in State

The Montana Department of Health & Environmental Sciences Public Health Laboratory isolated Influenza B virus from 3 isolates the week of January 9-13, 1989. Two isolates were from grade school age Bozeman residents. They were probably infected enroute from or while visiting in Michigan. Travel history for the other case is not yet determined but the case is a University of Montana student in Missoula. As of January 6, 1989, Influenza type B had been isolated from 14 states in the United States. "Type A (H3N2) virus and type A (H1N1) virus has also been reported from a few locations in the United States."[1]

1. Morbidity and Mortality Weekly Report.
   Centers for Disease Control, January 6, 1989
   Vol 37/Nos. 51 & 52, p. 789.

TRANSMISSION

Prostitutes and AIDS

The American Social Health Association suggests that health departments should place high priority on prevention efforts directed to prostitutes. Although HIV infection in prostitutes follows a different pattern than that for other STD's, prostitutes often have other risky behaviors, such as drug use.

The ASHA also reports that HIV infection in non-drug using prostitutes tends to be low or absent, while prostitutes who use IV drugs are far more likely to be infected with HIV. For prostitutes who do not use IV drugs, the greatest risk of infection may be from steady partners who may be infected with HIV and other STD's and with whom barrier protection is not used.

(American Journal of Public Health, April 1988, Vol. 78, No. 4, p. 418)

Heterosexual Transmission of HIV

In research reported at the International Conference on AIDS in Stockholm, a study from Africa highlighted risk factors that contribute to heterosexual transmission in that part of the world. Regular contact with a prostitute, the presence of genital ulcer disease, and the lack of circumcision were all significantly and independently associated with acquisition of HIV.

The epidemiology of heterosexual transmission in the U.S. also showed change. A CDC report shows that while heterosexual transmission still accounts for 4% of all AIDS cases, the percent of U.S. born cases has risen from 15% in 1982 to 68% in 1987.

(AIDSFILE, Vol. 3, No. 3, September 1988)

Adolescents and Behavior Change

A study conducted in San Francisco during the 1985-86 school year investigated changes in perceptions and condom use by sexually active teens. During that school year a one-class segment on AIDS was taught in the middle and high schools. Although perceptions that condoms prevent sexually transmitted diseases (STD's) and the value and importance placed on avoiding STD's remained high, these were neither reflected in increased intentions to use condoms nor in increased use.

Other studies demonstrate rapid, profound, but expectably incomplete alterations in the behavior of both homosexual/bisexual males and intravenous drug users. This is true in the highest risk metropolitan areas such as New York City and in areas with lower AIDS incidence. Risk reduction is occurring more frequently through the modification of sexual or drug-use behavior than through its elimination. However, longitudinal descriptions of individual behavior demonstrate considerable instability. Behavioral change in the potentially vulnerable heterosexual adolescent and young adult population is less common, as is risk reduction among urban minorities.

(American Journal of Public Health 1988; 78:460-461)

TREATMENT AND RESEARCH - Reports from Stockholm

(AIDSFILE, San Francisco General Hospital Medical Center, Vol. 3, No. 3, September 1988)

Zidovudine and Other Agents

Substantial evidence of progress in the area of antiviral therapy for HIV infection was presented at the Stockholm meeting. Most clinical trials reported results of research with well-known drugs, such as zidovudine. Substantial new work, however, is being conducted with other agents.

The use of zidovudine was the subject of several major abstracts. T. Creagh-Kirk et. al. of Burroughs Wellcome Co. reported on the long-term use of zidovudine given to several thousand patients under the treatment IND protocol. They confirmed data from Phase II trials, showing that zidovudine appears to be generally well tolerated, especially when used in patients with less severe HIV disease, and

appears to prolong survival by one or more years. (Abstract 3605)

M. Fischel et. al. reported on the results of a study from the National Institute of Allergy and Infectious Diseases of high- vs. low-dose zidovudine in patients with histories of Pneumocystis carinii pneumonia. To date, they have found no differences between a low dosage of 600 mg daily and a high dosage of 1,500 mg daily in this patient population. While final results are still pending, this work supports further exploration of a lower daily dose of zidovudine and is also consistent with reports from European investigators suggesting that less frequent dose intervals may be adequate. (Abstract 3606)

AL721

Active lipids are among the compounds that appear to have in vitro antiretroviral activity through blocking of virus adsorption to target cells. AL721 is a mixture of orally administered lipids which was developed by an Israeli group. Initial reports on its activity in humans were presented at the 1987 international conference in Washington, D.C. The drug has since become quite popular in the "alternative treatment underground," and is currently available at many health food stores in HIV-endemic areas.

Two abstracts from the Israeli investigators provided an update on their experience with AL721. Y. Skornick et. al. of Tel-Aviv Medical Center reported on 62 patients with AIDS and ARC who had been treated with the drug.

Clinical improvements and normalization of previously abnormal complete blood counts were reported in most treated patients. Only marginal changes were noted in immunologic parameters. Five patients had their HIV activity monitored during therapy by reverse transcriptase determinations. The investigators reported that after three months of AL721 treatment, HIV activity was reduced by 80% to 90% in these five patients. The poster presentation of this report noted that in some of these patients, zidovudine was added to the AL721 therapy prior to the reported reduction of reverse transcriptase activity. (Abstract 3529) It is somewhat disturbing that after such a lengthy clinical trial, detailed data are available on so few patients.

In the second abstract from Tel-Aviv Medical Center, I. Yust et. al. reported a reduction in circulating HIV antigen in seropositive persons treated with AL721. Thirteen HIV-seropositive patients entered this open trial of AL721 at a dosage of 10 g by mouth per day for three months. Five of the 13 patients were HIV p24 antigen-negative and virtually asymptomatic. Eight patients were antigen-positive, and two of them were reportedly virtually asymptomatic. Five of the eight antigen-positive patients lost antigen during AL721 treatment; the three nonresponders were all patients with previously diagnosed full-blown AIDS. (Abstract 3530)

Soluble CD4

One of the most exciting areas of in vitro work involves the use of soluble analogs of CD4, which is under investigation by several groups and companies. This agent consists of small, genetically engineered portions of the CD4 antigen, which is the cellular receptor for HIV. In theory, soluble CD4 should block the binding of HIV to the cell by occupying the gp120 binding sites on the surface of the virus. There were reports from British investigator A.G. Dalgleish et. al. and D. Capon et. al. of Genetech, Inc., on the in vitro use of soluble CD4. Both groups found that this compound binds avidly to gp120 and is a potent in vitro protector against HIV infection in otherwise susceptible cells. Capon reported that in preliminary animal toxicity trials, there were no adverse effects in doses capable of viral inhibition in vitro. (Abstracts 3061, 1524)

Treatment of Opportunistic Infections

Topics of presentations ranged from the common opportunistic infections, such as Pneumocystis carinii pneumonia, to the relatively obscure. Of particular

interest was the description of a new clinical problem, AIDS gastropathy, which may interfere with the effectiveness of ketoconazole therapy for oral or esophageal candidiasis.

G. Lake-Bakaar et. al. from the State University of New York at Brooklyn studied gastric acid secretory function in 23 AIDS patients. The pH of fasting gastric juice in these patients was significantly higher than that of control subjects, and maximal acid output was significantly lower than controls. Among seven patients with decreased maximal acid output, five failed to absorb ketoconazole, which requires an acid gastric pH for absorption. Ketoconazole absorption improved when the drug was co-administered with 20 millequivalents of hydrochloric acid. Antibodies against the parietal cell were seen in about half of AIDS patients tested, and this may explain the etiology of gastric secretory failure. The occasional failure of ketoconazole therapy to resolve oral or esophageal candidiasis may be due to gastric acid secretory failure. In such patients, an empiric trial of glutamic acid capsules (Acidulin) with oral ketoconazole might result in clinical success. (Abstracts 7113, 2501)

Abstracts from the conference may be obtained by writing: Catharina Ramel, Stockholm Convention Bureau, P.O. Box 6911, S 10239, Stockholm, Sweden. Cost for the 2-volume set is $50, payable on delivery. Do not send money with your order.

CURRENT STATISTICS

MONTANA AIDS CASES
Demographic Summary as of 10/15/88

CASES			SEX		
Reported Cases	24	100%	Female	3	13%
Reported Deaths	13	54%	Male	21	88%
				24	100%
AGE			RISK FACTOR		
Less than 5	0	0%	Homosexual/Bisexual Male	13	54%
5-12	0	0%	IV Drug Abuser	3	13%
13-19	0	0%	Homosexual Male & IVDA	2	8%
20-29	7	29%	Hemophilia, etc.	2	8%
30-39	12	50%	Heterosexual	3	13%
40-49	4	17%	Transfusion, Blood Components	0	0%
Over 49	1	4%	Undetermined*	1	4%
	24	100%		24	100%
RACIAL/ETHNIC GROUP			COUNTY OF DIAGNOSIS		
White	20	83%	Cascade	8	33%
American Indian	1	4%	Gallatin	1	4%
Black	1	4%	Lewis and Clark	2	8%
Hispanic	2	8%	Missoula	4	17%
Other/Unknown	0	0%	Silver Bow	1	4%
	24	100%	Yellowstone	5	21%
			Out-of-State Diagnosis	3	13%
				24	100%

Source: Montana AIDS Program, MDHES, December 15, 1988.

Note: There are eight (8) other AIDS cases which have been reported to MDHES. These were diagnosed and reported to Centers for Disease Control from other states. Those demographics are not included above.

As of December 30, 1988 there have been 175 positive HIV tests from 13,156 tests conducted through the DHES Public Health Laboratory.

* Includes patients on whom risk information is incomplete (due to death, refusal to be interviewed, or loss to follow-up, and patients still under investigation).

DECEMBER 1988	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		2											1		
Big Horn		5	1	1										8	
Blaine		4		1											
Broadwater															
Carbon		1										1			
Carter												1			
Cascade		23	1	3							5	1			1
Chouteau		1													
Custer		3										1			
Daniels															
Dawson	1	2													
Deer Lodge						2									1
Fallon															
Fergus		2									1	2			
Flathead			4	1		1									
Gallatin		25	2										1		
Garfield															
Glacier		11	1											37	
Golden Valley															
Granite															
Hill		3		2									1		
Jefferson															
Judith Basin												1			
Lake	1	3													
Lewis & Clark		5	2	1											
Liberty															
Lincoln		3													
McCone															
Madison															
Meagher															
Mineral														1	
Missoula	3	11		1		1					1				
Musselshell															
Park		1		1											
Petroleum															
Phillips															
Pondera				1											
Powder River												1			
Powell															
Prairie															
Ravalli		4				3									
Richland															
Roosevelt		8		13									1	1	3
Rosebud		4		3										2	
Sanders															
Sheridan															
Silver Bow		5				1	1				2				
Stillwater															1
Sweet Grass													3		
Teton															
Toole															
Treasure															
Valley		1													
Wheatland															
Wibaux															
Yellowstone		23	2	4			2					2	1		1
MONTHLY TOTAL 19 88	5	150	13	32	0	8	3	0	0	0	9	10	8	49	7
MONTHLY TOTAL 19 87	4	*308	24	58	1	1	9	2	2	0	6	20	3	14	7
MONTHLY TOTAL 19 86	0	73	15	52	0	4	2	1	0	1	5	16	1	3	7
TOTAL TO DATE 19 88	84	1934	204	410	10	47	56	10	4	1	95	112	97	261	38
TOTAL TO DATE 19 87	39	1754	176	616	19	87	59	11	5	4	122	145	74	42	22
TOTAL TO DATE 19 86	61	662	224	691	25	79	51	11	10	11	119	207	52	26	34

OTHER DISEASES: Aseptic Meningitis: Gallatin, 1; Chickenpox: Gallatin 2; Madison, 2; Yellowstone, 59; Cytomegaloviral Illness: Deer Lodge, 1; Hib Invasive Disease: Dawson, 1; Yellowstone, 1; Legionellosis: Missoula, 1; Measles, indigenous: Flathead, 48; Silver Bow: 4; Pertussis: Yellowstone, 2

*Monthly Chlamydia totals for 1987 are for November & December combined.

RESISTANT GONORRHEA (PPNG) FOLLOW-UP
Southeastern Montana

A case of PPNG was reported in last month's Morbidity Report. He was treated on December 5, 1988 in Yellowstone County. He has been interviewed and two of three contacts have been examined with negative cultures and epidemiologically treated. The third contact has not been identified or treated.

Although the source of the infection has not been identified, a possible source is a woman returning from out-of-country last fall who was one of those mentioned above as treated. That patient was interviewed and three of her five contacts have been examined and treated, with only the index patient having a positive report. The other two contacts have not been identified.

Due to a concern PPNG may still be present in the area, health care providers in Big Horn, Carter, Carbon, Rosebud, Treasure and Yellowstone Counties are asked to consider the following recommendations through the first three months of 1989:

1. Culture all specimens from symptomatic male or female patients, in addition to any smears collected and analyzed.

2. Ensure positive cultures are tested for beta-lactamase production at the local laboratory or are sent to the MDHES Public Health Laboratory.

3. Report all gonorrhea cases immediately to your local public health agency.

4. Ensure test of cures on all gonorrhea patients (especially women) 4-7 days after completion of therapy. Rectal cultures should be obtained from women treated for gonorrhea, regardless of whether rectal gonorrhea was documented prior to therapy.

5. Screen patients with a history of travel (within 60 days) to foreign or domestic areas of high prevalence of PPNG or with recent exposure to prostitutes.

6. Treat gonorrhea patients with the alternate treatment, ceftriaxone or spectinomycin, followed by tetracycline or doxycycline.

If you have any questions or comments, call or write the STD Program in Helena, 444-4740.

Volume: 12:13 **Month of:** December, 1988

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1988 ANNUAL SUMMARY

	Campylobacter, diarrhea	Chlamydia, sexually-transmitted	Giardiasis	Gonococcal disease	Haemophilus influenzae meningitis	Hepatitis A	Hepatitis B	Hepatitis, Non-A, Non-B	Hepatitis, unspecified	Meningococcal meningitis	Post-exposure rabies treatment	Rabies in animals	Salmonellosis	Shigellosis	Tuberculosis
Beaverhead		18	1	2									1		
Big Horn		62	3	15		1	1				5	12	5	131	1
Blaine		28	1	4								9			
Broadwater	2	1	1												
Carbon	1	5									1	13	2		
Carter											4	4			
Cascade		224	24	74	1	2	7	4			10	11	6		8
Chouteau	1	5		1									1		
Custer		23		2			1				2	4			
Daniels												3			
Dawson	2	12		5			1					1			
Deer Lodge		17	10	3		2							1	1	1
Fallon		1	1			1					2	1			
Fergus		14	8	1			1				5	34	2		
Flathead	6	80	6	15	1	9	4				6	4	3		
Gallatin	12	248	26	11	1	1	2				3	1	5	4	
Garfield		2									13	8			
Glacier		92	4	38							14	1	1	79	
Golden Valley												6			
Granite												1			
Hill	1	68	4	9		3	3				1	6	3	1	1
Jefferson		5	4				1						1		
Judith Basin	1											8			
Lake	2	39	2	6			2	1				1			2
Lewis & Clark		140	10	17		2	3				1	1	10	3	1
Liberty		2	1										2		
Lincoln	1	48	1			1		1							
McCone												6			
Madison	2	2				1	2						1		
Meagher															
Mineral		7		1										1	
Missoula	24	181	29	18	2	5	9				5	3	10	1	2
Musselshell	1	4	1								3	8	6		
Park		12	3	4	1		2				1		1		
Petroleum												1			
Phillips		4		3								1			
Pondera		4	1	8		1			2			9		1	
Powder River		1									1	4	1		
Powell	2	4	1	1							1				
Prairie							1								
Ravalli	3	31	1	2		5							2	1	
Richland		4		2	2					1		1	1		
Roosevelt		90	4	75		2						11	3	7	11
Rosebud		46		22		1					4	2	5	23	2
Sanders	1	3	1	2		1									
Sheridan		1	3									1			
Silver Bow	7	72	32	3	1	3	2				3	1	3	1	1
Stillwater	1	6									1				
Sweet Grass		1					1	1			3	1	3		
Teton	1	1	1			1						2			
Toole				1							6	7			
Treasure												3			
Valley	2	4		1					1				2		
Wheatland		1										1			
Wibaux		2													
Yellowstone	10	343	19	75	1	5	11	3	1			23	15	7	9
year to date TOTAL 1988	83	1958	203	*421	10	47	55	10	4	1	95	214	96	261	39
year to date TOTAL 1987	39	1775	177	*619	18	86	59	11	5	4	121	185	74	42	21
year to date TOTAL 1986	63	666	229	*691	28	84	51	11	9	11	119	205	65	27	34

* Gonococcal Disease Totals:
1988 includes 20 military & 2 PPNG
1987 includes 28 military
1986 includes 25 military

(Chlamydia reporting voluntary until November, 1987)

STATE DOCUMENTS COLLECTION

APR 26 1989

MONTANA STATE LIBRARY
1515 E. 6th AVE.
HELENA, MONTANA 59620

AIDS - 11

Amebiasis - 2

Flathead - 1
Missoula - 1

Aseptic Meningitis - 5

Gallatin - 2
Glacier - 1
Roosevelt - 1
Yellowstone - 1

Bacterial Meningitis Unspecified - 2

Missoula - 1
Valley - 1

Chickenpox - 728

Big Horn - 6
Cascade - 167
Custer - 18
Dawson - 3
Fergus - 20
Flathead - 41
Gallatin - 5
Glacier - 1
Hill - 5
Judith Basin - 13
Lake - 80
Liberty - 15
Madison - 2
Missoula - 7
Silver Bow - 37
Stillwater - 2
Wheatland - 13
Yellowstone - 293

Colorado Tick Fever - 19

Beaverhead - 3
Deer Lodge - 1
Gallatin - 2
Lewis & Clark - 1
Madison - 2
Missoula - 3
Ravalli - 5
Yellowstone - 2

Cytomegalo Viral Illness - 2

Deer Lodge - 1
Fergus - 1

Hib Invasive Disease - 9

Cascade - 1
Dawson - 3
Flathead - 1
Gallatin - 1
Yellowstone - 3

Influenza - 122

Legionellosis - 3

Cascade - 1
Missoula - 1
Ravalli - 1

Malaria - 5

Flathead - 1
Missoula - 1
Park - 1
Yellowstone - 2

DM/vg-29xt

PLEASE RETURN

Measles, Imported - 31

Flathead - 10
Gallatin - 1
Lincoln - 1
Park - 19

Measles, Indigenous - 55

Flathead - 48
Park - 5
Silver Bow - 2

Mumps - 2

Yellowstone - 2

Orinthosis - 2

Dawson - 2

Pertussis - 4

Lewis & Clark - 1
Missoula - 1
Yellowstone - 2

Rocky Mountain
Spotted Fever - 6

Big Horn - 1
Cascade - 1
Musselshell - 1
Park - 1
Ravalli - 1
Sheridan - 1

Rubella - 0

Step Pneumo Meningitis - 1

Cascade - 1

Strep Throat - 2491

Syphilis, Primary - 3

Cascade - 1
Yellowstone - 2

Syphilis, Secondary - 1

Yellowstone - 1

Syphilis, Early Latent -
Under 1 year - 5

Cascade - 1
Flathead - 1
Roosevelt - 1
Yellowstone - 2

Syphilis, Early Latent -
Over 1 year - 1

Lincoln - 1

Syphilis, Late Latent - 2

Yellowstone - 1
Sanders - 1

Typhoid Fever - 1

Gallatin - 1

Yersiniosis - 2

Gallatin - 1
Missoula - 1

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Month of:

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